FINAL REPORT

TASK FORCE FOR MOTHERS AND UNBORN CHILDREN

STATE OF MISSOURI

January 11, 1990

Task Force Report

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Forenote: The full text of all reports to the Task Force and all documents of the Task Force are set forth in a separate Appendix delivered with this report to the Governor.

The Task Force on the Health of Mothers and Unborn Children was instituted by Governor John Ashcroft on July 28, 1989. The Governor, in recognizing Missouri's long-standing tradition of encouraging childbirth over abortion, announced the formation of the Task Force to advise the executive branch and to assist the legislature in formulating means of reducing the numbers of abortions and encouraging childbirth over abortion.

The Task Force was charged to "identify those areas touching on the health of pregnant women and unborn children where additional state regulation or legislation would be appropriate." The Task Force was not to draft specific legislation since that is the function of the legislative branch. The Task Force was further directed to "focus on devising a strategy that identified those areas offering the state the maximum opportunity to promote maternal health and to protect the life of unborn children."

The Task Force directed questions to each state department that serves mothers and unborn children and held a public meeting. Some of the information for this report is derived from their responses to our questions. The Task Force appreciated the cooperation of the department personnel and was pleased to discover that none of the departments encourage abortion among the pregnant women served in the state, but at the same time, there appears to be no systematic effort among the departments to encourage childbirth over abortion. (The written questions and responses are set forth in Appendix A of this report.)

The Task Force believes that the unavailability of prenatal care and appropriate support during pregnancy are factors causing some women to choose abortion over childbirth. Legislation should be passed in Missouri both to reduce the numbers of abortions and to provide more prenatal and postnatal care. In essence, the same barriers to prenatal care in Missouri (1), especially the financial, transportation educational and motivational barriers, may be barriers to choosing childbirth over abortion. Remove these barriers, the Task Force believes, and some women will choose not to have abortions.

The Task Force concentrated on seven areas relating to abortion and maternal and infant care: Missouri abortion statistics; licensure of abortion clinics; pregnant women in prison; unborn and born babies affected by drug and alcohol problems; health and welfare of mothers and children; adoption; and abortion regulations being considered by other states that could be considered by the Missouri General Assembly. The Task Force's findings and recommendations in each area are as follows:

1. Missouri Abortion Statistics.

Findings of the Task Force.

In 1988, 76,101 children were born to Missouri women and 18,379 Missouri women had abortions. Thus, about one of every five pregnancies (19.5%) ended with abortion (2). The Department of Health reported that 15,658 (85.2%) of these abortions were performed within the first 12 weeks (first trimester) of pregnancy; 1,746 (9.5%) were performed after 12 weeks (second and third trimesters) of pregnancy; and 975 (5.3%) of these abortions were performed at unknown weeks of gestation (3).

Seventy-seven percent of the Missouri women having abortions in 1988 were unmarried (4). About one of every 10 abortions (1,958) was performed on women under 18 years of age (5).

Over one-third (34.3%) of Missouri women who had abortions in 1988 had one or more previous abortions (6). This repeat abortion rate has increased over the years from 16.5 percent of the women who had abortions in 1975-77 to 24.2 percent in 1975-80 to the present 34.3 percent (7).

For the 1,963 (10.7%) of Missouri women who had abortions in 1988, it was their third or greater abortion in their lifetimes. Some reported six or more previous abortions (8).

From 1973-1988 there were six abortion-related maternal deaths in Missouri. (See Appendix A, Department of Health response.)

Although the department annually compiles and publishes detailed statistical information on abortions and abortion complications as required by state law (Sections 188.052 and 188.055, RSMo), it seems that only the abortion complications that show up immediately at the time the abortion is performed are reported by the department. (See Appendix A, Department of Health response, Report of the Panel to Evaluate the U.S. Standard Certificates and Reports, Division of Vital Statistics, National Center for Health Statistics, Hyattsville, MD, p. 154-55. (April 1986).)

Missouri does not require a woman to provide reasons for her abortion, thus no data is available as to specifically why Missouri women obtain abortions. However a recent national survey does provide information on why women obtain abortions. The survey was conducted by the Alan Guttmacher Institute through questionnaires distributed to abortion patients. Respondents were allowed to give more than one reason for their abortion. One thousand nine hundred women responded to the survey. The Alan Guttmacher Institute is the research arm of Planned Parenthood. The survey found:

- only 1 percent have abortions because the pregnancy resulted from rape or incest;
- 3 percent have abortions primarily because the mother has a health problem;
- 3 percent have abortions primarily because the unborn child has a possible health problem;

- 76 percent of the women have abortions because of concern about how having a baby could change their lives. Two-thirds of this group say a baby would interfere with job, employment or career, and one-half of this group say having a baby would interfere with school;
- 38 percent of never-married women say they are having an abortion because they don't want others to know they had sex or are pregnant;
- 26 percent have abortions because they already have all the children they wanted or have all grown-up children (9).

Recommendations of the Task Force.

While the department provides one of the more comprehensive abortion statistics published in the nation, the Task Force is disturbed by the significant number of abortions reported to the department which lack information on the gestational age of the unborn child at the time of the abortion. The department should aggressively investigate abortion reports from Missouri abortion providers that do not include gestational age, to determine if these abortions are being performed after viability in contravention of the restrictions and safeguards required by state law.

The department should conduct and publish a study of the long-term physical and emotional effects (sometimes referred to as post-abortion syndrome) on women from abortions, and in particular increased risks to women who have had repeat abortions (34.3% of the abortions). Likewise, a study on reasons Missouri women obtain abortions, similar to the Alan Guttmacher report, and social or other factors that induce women to choose abortion over childbirth, should be undertaken.

2. Licensure of Abortion Clinics.

Findings of the Task Force.

Under Missouri's Ambulatory Surgical Center Licensing Law (Sections 197.200 - 197.240, RSMo), and implementing regulations, the Department of Health licenses any abortion clinic that meets the definition of an ambulatory surgical center.

Possibly nine abortion clinics (10) should be licensed under the law; however, only one such clinic is currently licensed. (See Appendix A, Department of Health response.)

Enforcement of this law as to the other abortion clinics in the state has been held in abeyance by the Department of Health pending the outcome of Turnock v. Ragsdale, a case on appeal to the U.S. Supreme Court from the 7th Circuit Court of Appeals. At issue in Turnock v. Ragsdale is the constitutionality of an Illinois statute and regulations similar to Missouri's ambulatory surgical center licensing law.

However, the Attorney General of Illinois recently announced a settlement agreement with the plaintiffs in the case, and it appears that the Supreme Court will not rule on the constitutionality of Illinois' statute and regulations.

Reports from Florida in October, 1989 disclosed that three outpatient abortion facilities in that state were closed because:

- state health inspectors found dead cockroaches, no sterile gloves, inoperative hot water faucets and outdated medicine and supplies at one abortion clinic (11);
- another clinic had an unlicensed doctor perform abortions which resulted in one woman's death and serious injury to several others (12);
- an abortion clinic operator paid staff members bonuses when they convinced women to undergo general anesthesia before an abortion, rather than less expensive and safer local anesthesia (13).

Similar stories in Chicago in 1978 of abortion clinic abuses as reported by the Chicago Sun Times, including abortions on non-pregnant women and previously unreported abortion clinic deaths, led to the outpatient facility licensing law passed by the Illinois legislature.

Medical consequences of abortion may include serious complications such as uterine perforation, serious hemorrhage, uterine scarring, or cervical canal damage causing an incompetent cervix. Fortunately such sequellae are rare in the hands of a competent and experienced physician (see Appendix B and citations therein).

Recommendations of the Task Force.

All abortions should be performed, therefore, in either a hospital or a certified out-patient surgery facility. Doctor's offices performing abortions should be registered and certified as out-patient surgery centers.

The department and Attorney General should energetically enforce Missouri's Ambulatory Surgical Center Licensing Law. All abortion clinics that come under the law should be licensed if they adequately meet the health and safety requirements imposed by departmental regulations, or shut down if they pose a health hazard to the residents of this State. If additional statutory authority is deemed necessary by the Attorney General to protect the public from abuses like those reported in other states, the Attorney General should suggest specific statutory amendments.

3. Pregnant Women in the Correction System of Missouri.

Findings of the Task Force.

According to the Department of Corrections and Human Resources, all female inmates entering state correctional facilities are checked for pregnancy and venereal disease. The great majority that are pregnant upon arrival have never received prenatal care, which is complicated by histories of drug abuse among these inmates and, in general, poor health habits.

According to the department, pregnant inmates are referred to an OB/GYN physician within two weeks upon arrival, or within 24 hours if the pregnant inmate is considered high risk or otherwise experiencing pregnancy-related problems.

Delivery is provided at Callaway Hospital or Hedrick Medical Center, and after delivery the inmate decides whether to place the child for adoption (through the Division of Family Services), or to have a family member claim the baby at the hospital. (See Appendix A, Department of Corrections response.) In 1988, there were 18 births to prison inmates, and in 1989, over 30 births.

While the Task Force found that the department does not encourage abortions for inmates, it also appears that there are no services or programs provided to inmates to encourage childbirth over abortion.

A recent study (14) of 26 pregnant inmates who gave birth in two midwestern prisons found that all the inmates perceived their pregnancy experiences in prison as negative, most thought they did not receive adequate prenatal care, and with the exception of one inmate, none of the inmates had the support of significant others during their hospitalizations for labor and delivery or the remainder of their hospital stays. All the inmates expressed anger, regret and depression when reflecting upon separation from and inability to care for their infants.

Of the 26 women, 20 were identified as having complications during their pregnancies, and of the 26 newborns, four had complications and were placed in neonatal intensive care units.

The women whose infants were in intensive care felt especially angry because they could not visit their infants after the women were discharged from the hospital and returned to prison, and the infants could not visit their mothers in prison.

Recommendations of the Task Force.

At a minimum, the department should offer childbirth preparation classes to all of its pregnant inmates. These classes should include breathing, muscle relaxation and pushing techniques for labor and delivery; information on fetal development; effects of smoking and substance abuse on the unborn child; and proper nutrition to benefit both mother and child. In addition, a husband, father, other family member, friend or volunteer caregiver should be allowed to assist a pregnant inmate during labor and delivery in the prison hospital. There should be a greater linkage between the Department of Health and Department of Corrections and Human Resources in providing adequate health care to mothers and children.

The department should consider small maternity units staffed by nurse practitioners on a part-time basis to provide antepartum and postpartum care. Correctional officials should consider providing separate prison wings for new mothers and their infants to reside for up to a year or so after delivery to ensure adequate maternal-infant bonding, ability to breast feed, and to alleviate burdens on family members outside of prison who would otherwise be caring for her child.

Alternate, less expensive solutions would be greater use of community-based alternative sentencing and a departmental policy of allowing a furlough for pregnant inmates who would pose no threat to society, self or

baby if released early from prison. Furloughs should include the period before delivery and a bonding period after delivery.

4. Born and Unborn Babies Affected by Drug and Alcohol Problems.

Findings of the Task Force.

A 1988 survey conducted by the National Association for Perinatal Addiction Research and Education found that on average 11 percent of pregnant women used heroin, methadone, amphetamines, PCP, marijuana, and most commonly, cocaine. Babies exposed to narcotics in the womb are frequently born addicted, and suffer from withdrawal that makes their care difficult for their mothers. (See Appendices A and B, Department of Health response.)

Babies born to mothers who used "crack" cocaine during pregnancy, if they survive until birth, tend to be born prematurely; are of low birth weight; are jittery, irritable or lethargic; are subject to strokes, birth defects and sudden infant death syndrome; and may have learning disabilities and behavioral problems as they grow older. (See Appendix B)

Mothers who use alcohol during pregnancy may subject their unborn children to Fetal Alcohol Syndrome (FAS) that can result in growth deficiencies, skeletal deformities, facial abnormalities, organ deformities and central nervous system problems. FAS occurs in 38 to 51 Missouri births per year. Some of the less severe symptoms known as Fetal Alcohol Effects, may occur in as many as 1,000 Missouri births a year. (See Appendix B)

Clearly the most cost-effective means of treating these children is treating their mothers before birth. (See Appendix B)

According to the Department of Social Services, if a report is made to the child abuse hotline that a pregnant women is abusing alcohol or drugs and her unborn child may be adversely affected, such report is not accepted by the department as an appropriate report. The caller is advised to call back when the child is born -- if the alcohol or drug abuse still exists and is affecting the child. (See Appendix A, Department of Social Services response.)

Recommendations of the Task Force.

The Task Force recommends that the General Assembly fund the Governor's drug control strategy, part 1, as proposed November 16, 1989. Funding must be provided so that treatment facilities can be offered to all drug abusing pregnant women and mothers who desire help, but who would otherwise be placed on long waiting lists. Mothers who refuse help should be followed by social service teams, because their children are at high risk for prenatal and postnatal child abuse.

Documented known drug abuse during pregnancy should be reported to the child abuse hotline, and home investigation and supportive services by the Department of Social Services should be provided.

Mandatory public school health education campaigns are needed to inform students of the serious health risks of alcohol, drug use and smoking during pregnancy. (See additional Task Force recommendations in Section 5 below.)

5. Health and Welfare of Mothers and Children

Findings of the Task Force.

Availability of prenatal care and appropriate support during pregnancy may be a factor promoting choice for an abortion. Obviously, should abortion be limited, more prenatal care would also be needed. The Task Force finds a lack of available adequate prenatal care exists within some areas of the state. Four factors have been identified as important in limiting availability of prenatal care in Missouri. (See Appendix B and citations therein.)

1) Financial. Inability to pay for proper private medical care and inadequate funding by the State of Missouri to ensure adequate public providers of prenatal care are major factors.

2) Educational. Many teenagers and other pregnant women still do not recognize the importance of adequate prenatal care. In addition, they do not realize that public funding and support may be available. There is a lack of education at the primary and secondary levels of education in terms of the necessity for adequate prenatal care (see Appendix A). Mandatory public school health education and public informational campaigns are needed.

3) Transportation. In rural areas one to two hour drives may be required to see a doctor for prenatal care. Much could be accomplished with well funded local Health Clinics staffed by traveling teams or nurse practitioners.

4) Motivation to obtain prenatal care. It is very difficult to motivate women to properly care for themselves when they are carrying an unwanted pregnancy. More educational effort is needed in promoting appropriate family planning, promoting the adoption alternative, and in promoting special programs to foster abstinence for unwed teenagers.

The 1990 legislative session of the General Assembly of the State of Missouri will be considering bills to improve availability of prenatal care in the State of Missouri.. This must be a number one top priority in our state.

Recommendations of the Task Force.

The Governor's Task Force on Mothers and Unborn Children recommends funding of current bills to provide increased financial support to ensure adequate provision of prenatal care to all citizens of the State of Missouri.

The Governor's Task Force recommends a greater educational effort to prepare promotional material to public media andto school systems as to the importance of adequate prenatal care, and also in the avoidance of drug, alcohol and tobacco use during pregnancy. Our recommendations should be made to the General Assembly to require completion of Health Education for high school graduation.

The Governor's Task Force recommends the establishment and appropriate funding of local Health Clinics available for prenatal care, such that transportation, especially in rural areas, need not be such a limiting factor.

The Task Force recommends the full support of the Missouri General Assembly to expand existing Medicaid coverage to pregnant women and children and to simplify procedures for low-income mothers to become eligible for services, i.e., "presumptive eligibility".

The Task Force enthusiastically endorses Governor Ashcroft's proposal to increase reimbursement to physicians for treating pregnant women under Medicaid.

The Task Force recommends establishment of a toll-free hotline to provide information on doctors and clinics serving Medicaid recipients.

The Task Force supports the Family Support Act and similar measures aimed at providing adequate availability of child care and better opportunities for low income mothers.

6. Adoption.

Findings of the Task Force.

According to the Division of Family Services, 542 children were placed for adoption through the division in 1988. Twenty-five of these children adopted were under one year of age; 58 were one year old; 42 were two years old; 55 were three years old; and 362 were over three years old at the time of their adoption. These figures do not include the number of children placed through private adoption agencies. As of October 1, 1989, 372 children in division custody were awaiting adoption, most of whom were over three years of age.

Children of minority racial or ethnic heritage, who have physical or mental handicaps, or who are members of a sibling group needing placement together are considered to have special needs. According to the division, special needs such as these could cause it to take longer to find an appropriate family to meet the child's needs, however, only in very rare circumstances does the division claim that it is unable to place a young child for adoption within a reasonable length of time. The division says it has experienced much success through its recruitment efforts even in placing severely handicapped young children.

Children available for adoption generally remain in foster care until an adoptive home is found. Only in rare instances, according to the division, would a young child be placed in a residential facility pending adoption.

According to William L. Pierce, president of the National Committee for Adoption, as many as one million American couples are unable to have children of their own but only 50,000 children are available for unrelated domestic adoptions (15). Thus, according to Pierce, Americans adopted 10,019 foreign babies in 1987, a 46 percent increase over the foreign adoptions in 1977. Most of these children came from the Asian continent.

According to the National Committee for Adoption's "Adoption Factbook," in Missouri in 1986, there were 905 unrelated domestic adoptions, 1,755 related domestic adoptions, and 304 foreign adoptions.

A recent poll of Ohio residents (16) found that 87 percent believe a woman should be required to receive counseling about placing the baby for adoption before an abortion can be performed, 11 percent opposed it and 2 percent were undecided.

A July 1989 poll conducted for Time magazine (17) found 81 percent of Americans support requiring doctors to inform patients about alternatives to abortion, with 16 percent opposed.

Recommendations of the Task Force.

Legislation should be considered requiring abortion facilities to ensure that patients have received adoption counseling before they can obtain an abortion.

7. Abortion Regulations.

Findings of the Task Force.

From the early years of statehood, Missouri has regulated abortions, dating back to 1825. The laws prohibited abortion, except to save the life of of the mother. That tradition, interrupted in 1973 by Roe v. Wade is now able to be resumed. Now, with the decision in Webster v. Reproductive Health, states are once again invited to enact legislation to limit abortion. Even prior to Webster, the State of Missouri enacted laws restricting abortion (see Appendix D).

Since the Webster decision, only a few state legislatures have dealt with abortion legislation. Some of the more significant developments in state legislatures since July include:

Pennsylvania.

- Legislation approved by the legislature and signed by the governor bans abortions after the 24th week of pregnancy except to save the mother's life and in cases where "substantial and irreversible impairment of major bodily function" was threatened;
- Requires a 24-hour waiting period before a woman can obtain an abortion;
- Requires a woman to notify her husband if she plans to get an abortion unless the husband is not the father of the child, the husband cannot be located, the pregnancy is the result of spousal rape that has been reported to the police, or if telling the husband would put the woman in danger of abuse;
- Prohibits sex-selection abortions;
- Permits experimentation with tissues from aborted children only with the permission of the woman who had the abortion;
- Requires physicians to test for the fetal age before doing an abortion and inform women of the availability of services to carry the unborn child to term at various stages of development.

Michigan

- The legislature is considering a bill requiring parental consent before girls 17 or younger could obtain abortions.

Louisiana

- The Attorney General and New Orleans District Attorney have asked a three-judge panel of federal judges to reinstate Louisiana's pre-Roe abortion law banning all abortions except to save the life of the mother. The Louisiana legislature had asked the Attorney General to seek the lifting of an injunction prohibiting enforcement of the law since the mid 1970's. Both the Attorney General and the district attorney hope their effort is a test case to get a Supreme Court ruling on whether Louisiana can indeed ban abortion.

Florida

- Florida House and Senate committees considered various abortion proposals and alternatives to abortion initiatives during a special session of the legislature, but no bills were reported out of committee. The bills included proposals to:
- Ban public financing for abortions;
- Require viability tests on the unborn children of women at least 20 weeks pregnant;
- Require physicians to tell women seeking abortions about the development of their unborn children;
- Toughen clinic regulations in light of three south Florida clinics being closed by the state for unsanitary and unsafe conditions;
- Create a state center to promote adoption as an alternative to abortion;
- Put abortion restrictions before voters in the form of a constitutional amendment that would have allowed counties to raise property taxes to pay for the care of poor, pregnant women and their babies, and would have restricted abortions to cases involving rape, incest, the health of the mother and handicapped fetuses.

Wisconsin

- A Wisconsin House committee considered a bill requiring parental consent for minors before an abortion, but no action was taken before the legislature adjourned.

Illinois

- A committee of the Illinois House considered but did not pass a bill similar to the Missouri legislature's restrictions on abortion, which were upheld in July by the U.S. Supreme Court.

Recommendations of the Task Force.

The ultimate goal of legislation and policy-making in the State of Missouri should be the promotion of childbirth as the outcome of pregnancy, the elimination of induced abortion by removal of impediments to choosing childbirth, and the imposing of legal restrictions to reduce the number of abortions.

This Task Force recommends that the General Assembly enact appropriate legislation without delay to protect the right to life of unborn children.

Members of the Task Force:
Mrs. Diane Baker, Kansas City
Rev. Charles J. Briscoe, Kansas City
Dr. Yvonne Bussmann, Springfield
Mr. Louis C. DeFeo, Jr., Jefferson City
Mr. F. Douglas Kneibert, Sedalia
Mrs. Loretto Wagner, St. Louis

Appendicies:
A - Questions to and responses of state Departments.
B - Bussmann
C - Wagner
D - Dr. William Otto

FOOTNOTES:

1. "Barriers to Prenatal Care in Missouri," Missouri Monthly Vital Statistics, October, 1988.

2. Missouri Vital Statistics 1988, State Center for Health Statistics, Department of Health, Jefferson City, MO. (July 1989).

3. Ibid.

4. Ibid.

5. Ibid.

6. Ibid.

7. Trends in Missouri Abortions 1975-1980, Missouri Center for Health Statistics, Division of Health, Department of Social Services, Jefferson City, MO. (June 1982).

8. Missouri Vital Statistics 1988.

9. Torres & Forrest. "Why Do Women Have Abortions?" Family Planning Perspectives 20(4): 169, 170 (July/August 1988).

10. Trends in Missouri Abortions 1975-1980, p. 28.

11. "State Closes Third Abortion Clinic," UPI, October 5, 1989.

12. Ibid.

13. "Abortion Clinic Urged General Anesthesia, Report Says," UPI, October 6, 1989.

14. Shelton & Gill. "Childbearing in Prison: A Behavioral Analysis" Journal of Obstetric, Gynecologic, and Neonatal Nursing 18(4): 301 (July/August 1989).

15. "Foreign Adoptions," AP, October 2, 1989.

16. "Ohioans Favor Counseling Before Abortion," UPI, October 26, 1989.

17. "The Battle Over Abortion," Time, July 17, 1989, p. 63.

Missouri Department of
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November 3, 1989

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Dear Mr. DeFeo:

The following are responses to the questions submitted by The Governor's Task Force on the Health of Mothers and Unborn Children.

QUESTIONS TO ALL AGENCIES

1. **What information does your agency have on women who are experiencing problems during pregnancy?**

a) Medicaid Case Management identifies women with the following risk factors:
- Age less than 15 years
- Less than 8th grade education
- Gravidity greater than or equal to 7
- Smoking, one or more packs daily
- Age greater than 40 years
- Inappropriate pre-pregnancy weight
- Previous fetal death
- Previous infant death
- Diabetes
- Multi-fetal pregnancy
- Hypertension
- Pregnancy induced hypertension
- Psycho-social risk factors
- Prior low birth weight
- Prior premature labor
- Alcohol use
- Substance abuse
- Other risk factors identified by the case managers

b) The Missouri Department of Health High Risk Maternity and Child Care Program (1686) identifies prenatal women with the complications of pregnancy. See attached list for criteria.

c) The Missouri birth certificates collect data on various complications of pregnancy. See attached birth certificate.

2. **What information does your agency have on abortion?**

See attached report from the State Center for Health Statistics.

3. **What information does your agency have on the consequences of abortion in our state?**

No studies have been done in Missouri.

4. **What support services or programs does your agency provide or have knowledge of for pregnant women or their children to remove inducements or duress toward choosing abortion instead of child birth?**

None, although the Medicaid case management program does provide support services for Medicaid-eligible pregnant women.

5. **What is your understanding of the public policy of our state as expressed by the courts and legislature as to the preference between childbirth and abortion?**

Our state policy encourages women to carry their pregnancies to term and promotes childbirth over abortion. The Missouri Department of Health provides prenatal care and child health services but no abortion services.

6. **What information do you have as to any correlation between abortion and any of the following: school dropout, mental health problems, unemployment, poor health, substance abuse, imprisonment of woman or spouse, welfare dependency, lack of health insurance, family dysfunction?**

National studies reveal that teenage pregnancy is the major known cause of dropping out among school-age females in the United States. It is estimated that approximately 40% of young women who drop out of school do so for a pregnancy-related reason.

7. **Do any of the above factors induce women to choose abortion over child birth? What other factors induce women to choose abortion rather than child birth?**

No studies have been done in Missouri. A study on barriers to contraceptive use would be helpful.

8. **Does your agency have anyone responsible for research or data collection about abortion, its inducements or consequences? If so, who?**

The State Center for Health Statistics

9. **If a woman approached your agency with a pregnancy related problem, what services would your agency have to assist her? How are these services made known to those with potential need? Who is in charge of these services?**

The Missouri Department of Health funds 35 prenatal clinics which serve 99 counties and the city of St. Louis. See attached map. Financial assistance for high risk pregnancies is provided through the High Risk Maternity and Child Care Program. Case management services are provided for Medicaid-eligible pregnant women, nutritional services for pregnant women and children are provided through the WIC program. These programs are administered by the Division of Maternal, Child and Family Health.

10. **If a person (client, inmate, resident, etc.) under the care, custody or control of your agency seeks an abortion, what services do you provide her as to alternatives such as adoption?**

Women are referred to the Division of Family Services for adoption services. Referrals are also made to Birthright and to Catholic Charities and other adoption agencies.

11. **What additional substantive legislative authority would be beneficial to your agency in expanding services to women experiencing problems during pregnancy?**

a) Increased funding for family planning to prevent unwanted pregnancies.
b) More treatment services for pregnant alcohol and drug abusers. These services are currently underfunded and have long waiting lists.
c) Higher reimbursement levels for Medicaid case management services for pregnant women and children. Many agencies state that they are not adequately reimbursed for the services provided in this program.
d) Increased Medicaid reimbursement to physicians and hospitals for prenatal care and delivery.

12. **What policies and practices does your agency have to support your employees who are pregnant so that job conditions or interruption of employment opportunities do not become a factor inducing abortion over childbirth?**

The Missouri Department of Health (and the State of Missouri) has a 90 day maternity leave but once vacation time and sick days are used up, this is not a paid leave. This discourages new mothers from staying home with their new babies. There is no paternity leave for new fathers, and no on-site day care.

QUESTIONS TO THE DEPARTMENT OF HEALTH

1. **What state-subsidized health clinics or other facilities or programs are available in Missouri to indigent women for prenatal care, delivery and pediatric care? Indicate locations.**

   The Missouri Department of Health funds 35 prenatal clinics serving 99 counties and the City of St. Louis. See attached map for locations.

2. **What are the policies and programs of the state for women in prison regarding prenatal care, delivery, care and custody of infant after birth, and abortion referral?**

   This is addressed by the Department of Corrections, not Health.

3. **What programs are available to indigent pregnant women and mothers who have serious stress related problems that could lead to child abuse? i.e. short-term counseling and treatment.**

   The Medicaid case management program provides referrals to psychological and support services for women in need. In addition, pregnant patients at our prenatal clinics who are not Medicaid-eligible are also referred for appropriate psychological services, if needed.

4. **Is there any policy regarding private hospitals that (1) refuse Medicaid patients, (2) will accept Medicaid patients for delivery but have no prenatal clinics and make no effort or refuse to refer Medicaid patients to a doctor on staff for prenatal care?**

   We know of no policies. The Department of Health does not contract with any hospitals which do not accept Medicaid.

5. **What programs are currently being offered in Missouri for treatment and follow-up counseling after treatment for drug dependent pregnant women? Are there any plans for additional programs?**

   Treatment for drug and alcohol–dependent pregnant women is provided by the Department of Mental Health, but funding constraints have limited the availability of these services. Pregnant women do have a priority for services. We would like to expand these treatment services for pregnant women if additional funding can be obtained.

6. **State the information available regarding drug affected babies including the children of the homeless?**

   We have no idea of the extent of the problem of drug and alcohol–affected babies in Missouri. Prevalence studies need to be done to determine the extent of this problem.

7. **Identify known abortion facilities in Missouri.**

There are 20 facilities in Missouri which have reported abortions to the Department of Health in 1989. Sec 188.055.2 states "All information obtained by physician, hospital, or abortion facility from a patient for the purpose of preparing reports to the department of health under sections 188.010 to 188.085 or reports received by the department of health shall be confidential and shall be used only for statistical purposes." Because of this provision of the law, we cannot identify the facilities performing abortions.

8. **State the number of abortions performed in Missouri annually since 1973 according to facility. State age of mother and gestational age of child.**

Page 46 of the enclosed Missouri Vital Statistics 1988 provides information on the annual number of abortions performed since 1975. Table 12 on page 47 of the same report provides information on the age of woman and gestational age.

9. **Provide what data is available as to number of illegal abortions in our state before 1973.**

Since abortions were illegal before 1973, there was so state requirement to report such events. We have no information or estimate on the number of illegal abortions before 1973.

10. **What data is available on abortion deaths in our state after legalization (1973) to the present time and before legalization? Report abortion deaths separately (not included with deaths as a complication of pregnancy).**

From 1973-1988 there were six abortion related maternal deaths in Missouri. For a comparable number of years from 1957-1972, there were 35 abortion related maternal deaths.

11. **What is the number of abortions in our state by county of residence, age, education, marital status, substance abuse history, gestational age of unborn child, etc. by year. What is number of repeat abortions?**

The enclosed reports provide detailed information on abortions by socio-demographic characteristics.

12. **What are the known or declared reasons women in our state obtain abortions?**

The state report does not ask for the reason of the abortion.

13. **What reports are required on the performance of abortions in our state? Attach sample forms. Cite any regulations applicable to reporting.**

Enclosed are the forms which are used to report abortions and complications of abortions. The statutory basis for the reporting of abortions is Sec 188.052 and 188.055.

14. What action is taken by DOH to protect the public from abuses by abortion providers such as has occurred in Chicago and Dade County, Florida?

Under Sec. 197.200 the Department of Health licenses any abortion clinic that meets the definition of an ambulatory surgical center. Currently there is one abortion clinic so licensed. This clinic receives an annual inspection to determine compliance with Department of Health abortion clinic regulations. Hospitals which perform abortions are also licensed by the Department of Health and routine inspections are performed. To date we have found no instances and have had no complaints of the nature cited in other parts of the country.

I will not be available to appear at the public meeting on November 16. Charlie Stokes, my Deputy Director (751-6002), will testify in my place. He will have with him Garland Land, Director of our Division of Health Resources (751-6272). The Division of Health Resources collects statistics on infant mortality, abortions and other health indicators.

Sincerely,

Robert G. Harmon, M.D., M.P.H.
Director

RGH/MS/GL:ds

TO DEPARTMENT OF ELEMENTARY & SECONDARY EDUCATION:

1. What programs does DESE have or recommend for teachers, counselors, school nurses or administrators to support and assist students who are pregnant to choose child birth?

2. How many pupils dropout due to pregnancy related problems?

3. What programs do public school districts have for teaching paternal and maternal responsibility to students?

4. What alternative educational programs are provided by public schools for pregnant students?

5. What is the policy of public school districts regarding notification of parents is a child seeks an abortion?

6. What is the policy of public school districts if a student request dismissal from school without parental consent to have an abortion?

To The Department of Elementary and Secondary Education

1. The Department does not have a program designed especially for teachers, counselors, school nurses or administrators to support and assist students who are pregnant to choose child birth.

2. The Department does not collect this information.

3. Of the 544 public school districts in Missouri, there are 388 high schools in the state with approved vocational home economics programs. High schools with approved vocational home economics education programs include in their curriculum classes in family living and parenthood, child development and guidance, food and nutrition, and family and individual health. These programs focus on parenting and parenting skills as well as health competencies needed by a pregnant women to increase her chances of delivering a healthy baby. In the exploratory home economics courses offered at the junior high/middle school and high school level, there is a unit in self-appreciation and development of positive self-concept, which research indicates is a key to prevention of teenage pregnancy.

4. In the St. Louis area, samples of alternative educational programs provided by the public schools are the Continued Education School, established in 1968 and the Parent Infant Interaction Program at Vashon High School. Pregnant students in grades 5-12 may choose to attend the Continued Education School or remain in their home school. All girls must take a parent guidance course which covers topics such as childbirth, child development, nutrition, diseases of pregnancy, venereal diseases, contraceptives, and self-esteem.

   The Parent Infant Interaction Program (PIIP) offered at Vashon High School provides support and education to pregnant students and adolescent parents. Some of the services offered through PPIP are: prenatal groups, parenting groups, individual advisory sessions, home visits, daily school attendance monitoring, teen father support group, and the Crib Infant Care Center.

   The Pattonville School District has the Adolescent Parent Program which provides many of the same services offered at Vashon. A life skills course which is taught in the home economics program is required of all students enrolled in the program. The course emphasizes enhanced self-concept, information on prenatal care, pregnancy and parenting; problem solving, money management, and preparation for employment. Home visits during the time of confinement are made by the vocational home economics teacher to assist in school-related matters, to improve self-concept, and to reduce child-abuse.

   In the Kansas City area, the Teenage Parent Center has been in operation since 1970 and has several purposes: to prevent pregnant girls from dropping out of school, to improve the students' educational and job skills and to help maintain and/or improve the

health and welfare of the students during pregnancy, childbirth, and the postpartum time of their lives.

The Center is staffed by certified personnel, including a nurse, a counselor, and a part-time social worker. The academic program includes all levels of English, mathematics, biology, human science, world history, civics, speech, typing, etc.

In March, 1981 an infant care unit was opened in the Center for the purpose of helping students to develop their parenting skills and at the same time continue their education. Home economics, including family living is a part of the curriculum.

In Columbia, Missouri pregnant students may remain in their home school or attend pregnancy classes at Douglas School in the morning and academic classes at the Secondary Learning Center in the afternoon. Pregnancy classes cover topics such as foods and nutrition, prenatal care, child growth and development, and parenting.

The Springfield School District has the Prime-Time Junior Program which is housed in the home economics department of Central High School. This Incentive Grant program requires the pregnant teen or teenage parent to take a course in child development. Students may remain in their home school or transfer to Central where there an Infant Care Unit provided as a part of the Prime-Time Junior Program.

There is some alternative program available to almost every school district in the state. These include the homebound educational instructional program provided to students who are not able to attend the regular public school. Any student through the age of twenty who is pregnant may receive homebound instruction during a period of six weeks prior to and six weeks after delivery. If there are any medical complications, homebound instruction can be continued with appropriate authorization by DESE. Parents of pregnant students and the pregnant student work with the authorized local public school official to complete the homebound services application. The physician-approved homebound application is sent to the Director of Special Education, DESE, for approval. If the student needs more services than the standard six weeks prior to and after delivery, an extension may be granted by the Director of Special Education.

Homebound instruction is provided for at least five hours each week. The function of the homebound instruction is to assure that each student retains continuity in instruction during pregnancy so that education can be maintained to help the student persist to graduation.

The Division of Vocational and Adult Education, DESE, is authorized to administer the Carl D. Perkins Vocational Education Act of 1984 funds. Part of these funds are designated for programs, services,

and activities for girls and women aged 14 through 25 which enable the participants to support themselves and their families.

The division allocates funds to sixty-nine institutions in the state. Fifty-eight area vocational-technical school and eleven community college districts each receive an allocation and submit a plan to provide a program of services.

These services may include outreach; orientation and pre-enrollment activities with a focus on assessment and career planning; tuition assistance for training programs; basic literacy instruction; instruction for supplemental support services on a variety of topics, such as self-concept building, family-work relationships, job search training, job readiness training, and dependent care for children.

The purpose of these Carl Perkins monies is to make vocational education and training more available to single parents, which is what many teen parents are. The goal is to provide training necessary to obtain a marketable skill and to maintain a career sufficient to support themselves and their families.

Adult Basic Education (ABE) programs enable adults to acquire basic skills necessary to function in society by making available the means to secure training that will enable them to become more employable, productive, and responsible citizens.

Adults, 16 years and older, may take advantage of basic education opportunities by enrolling in an ABE program which is provided free of charge around the state. The ABE classes enroll pregnant teenagers whereby they are able to study for high school completion.

QUESTIONS TO ALL AGENCIES:

1. What information does your agency have on women who are experiencing problems during pregnancy?

2. What information does your agency have on abortion?

3. What information does your agency have on the consequences of abortion in our state?

4. What support services or programs does your agency provide or have knowledge of for pregnant women or their children to remove inducements or duress toward choosing abortion instead of child birth?

5. What is your understanding of the public policy of our state as expressed by the courts and legislature as to the preference between child birth and abortion?

6. What information do you have as to any correlation between abortion and any of the following: school dropout, mental health problems, unemployment, poor health, substance abuse, imprisonment of woman or spouse, welfare dependency, lack of health insurance, family dysfunction?

7. Do any of the above factors induce women to choose abortion over child birth? What other factors induce women to choose abortion rather than child birth?

8. Does your agency have anyone responsible for research or data collection about abortion, its inducements or consequences? If so, who?

9. If a woman approached your agency with a pregnancy related problem, what services would your agency have to assist her? How are these service made known to those with potential need? Who is in charge of these services?

10. If a person (client, inmate, resident etc.) under the care, custody or control of your agency seeks an abortion, what services do you provide her as to alternatives such as adoption?

11. What additional substantive legislative authority would be beneficial to your agency in expanding services to women experiencing problems during pregnancy?

12. What policies and practices does your agency have to support your employees who are pregnant so that job conditions or interruption of employment opportunities do not become a factor inducing abortion over childbirth?

Questions to All Agencies

1. None

2. None

3. None

4. This agency is not aware of any inducements or duress used to influence pregnant women or their children to choose abortion instead of child birth.

5. To the best of my knowledge, there is not a written public policy at the state level as to the preference between child birth and abortion. Policy inferences might be drawn from the fact that there is a law in Missouri that life begins at conception. While abortion is not illegal in Missouri, the legislators continue to pass laws that make it increasingly difficult for women to get an abortion. It is also the agency's understanding that the state will not fund abortions or that any Title X funds can be used for abortion. These facts might point toward a policy of child birth in perference to abortion.

6. None

7. This agency does not collect this type of information. At the national level there have been several studies regarding the factors that induce women to choose abortion rather than child birth. The Alan Guttmacher Institute is one such source of a national study.

8. No

9. Not applicable to this agency

10. Not applicable to this agency

11. Currently, this is not a task identified as a part of this agency's role. However, providing in-school health and pre-natal care to pregnant teenagers to help them stay in school and deliver a healthy baby is a goal that may need to be considered.

12. The Department's policy is that sick leave includes loss of time from employment due to pregnancy or childbirth on the same terms and conditions as are applied to other temporary disabilities. While on sick leave, employees continue to accrue leave as if they were actually performing duties. The Department will allow sick leave without pay for up to 12 months based on the written recommendation of a doctor. It is also the Department's policy to allow sick leave to be used for the care of sick family members.

    Employees who have personal problems which might have an adverse effect on their work performance are encouraged to obtain help

through the State Employee Assistance System (SEAS). The initial SEAS referral may be made during the normal workday on Department time, however, subsequent visits must be on the employee's time. The referrals are strictly confidential and are not made a part of the employee's personnel file. Any information concerning diagnosis, treatment, or participation in SEAS will not be released without the written permission of the employee.

STATE OF MISSOURI
OFFICE OF SECRETARY OF STATE
JEFFERSON CITY 65102

ROY D. BLUNT
SECRETARY OF STATE

314/751-

October 25, 1989

Mr. Louis C. DeFeo, Jr.
Post Office Box 720
Jefferson City, Missouri 65102

Dear Mr. DeFeo:

Secretary of State Roy Blunt has referred your letter to me.

Our office cannot identify a nonprofit corporation's specific purpose unless we have a person pull that corporate file folder and read through the Articles of Incorporation. Since our office has over twenty-two thousand active nonprofit corporations, the task of searching through each file folder to determine its purpose is beyond our capability. However, we can provide you with a computer printout of the name of all our nonprofit corporations. Possibly you can determine the information that you seek from those names.

Sincerely,

ROY D. BLUNT
Secretary of State

William L. Newcomb, Jr.
Chief Counsel

WLN:kaw

COORDINATING BOARD FOR HIGHER EDUCATION

101 ADAMS STREET • JEFFERSON CITY, MISSOURI 65101-3059 • (314) 751-2361 • FAX (314) 751-6635

JOHN H. KOFFMAN
CHAIRMAN

CHARLES J. McCLAIN
COMMISSIONER

October 25, 1989

Mr. Louis C. DeFeo, Jr.
Governor's Task Force on Health of
Mothers and Unborn Children
P.O Box 1022
Jefferson City, Missouri 65102

Dear Mr. DeFeo:

In response to the survey of all state agencies being conducted by the Governor's Task Force on Health of Mothers and Unborn Children, the Department of Higher Education does provide maternity leave for female employees (question 12) as permitted by the state's personnel policies. The department's personnel matters are handled on a part-time basis by Dr. Robert Jacob, Assistant Commissioner. The department has no information related to, or suggested by, questions 1 through 11.

In reference to the questions specifically posed to the Department of Higher Education, the department does not collect information about, or the type of data needed, to answer these questions. The issues related to these questions are within the area of responsibility of the respective institutional governing boards and campus health services offices rather than the state higher education coordinating board.

Cordially,

Charles J. McClain

lms

JOHN ASHCROFT
GOVERNOR

KEITH SCHAFER, Ed.D.
DIRECTOR

JOHN TWIEHAUS, DIRECTOR
DIVISION OF COMPREHENSIVE
PSYCHIATRIC SERVICES

GARY V. SLUYTER, Ph.D., M.P.H., DIRECTOR
DIVISION OF MENTAL RETARDATION AND
DEVELOPMENTAL DISABILITIES

LOIS OLSON, DIRECTOR
DIVISION OF ALCOHOL AND
DRUG ABUSE

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
1915 SOUTHRIDGE DRIVE
P.O. BOX 687
JEFFERSON CITY, MISSOURI 65102
(314) 751-4122

November 7, 1989

Louis C. DeFeo, Jr.
Governor's Task Force on Health of
Mothers and Unborn Children
P.O. Box 1022
Jefferson City, MO 65102

Dear Mr. DeFeo:

Dr. Schafer asked me to respond to your questions. I have coordinated our responses with officials of our three service divisions.

Our responses to the general task force questions are as follows:

1. Our agency distributes and/or develops educational materials for women who are pregnant to prevent problems either for themselves or their unborn children (e.g., we wish to prevent fetal alcohol syndrome which can cause developmental disabilities). Please contact me if you want copies of any such materials and I will have them forwarded to you. We also try to coordinate our educational efforts with the Department of Health on this subject.

2. We do not have any information on abortion.

3. We do not have any information on the consequences of abortion in our State.

4. We believe our support services or programs are neutral as to abortion or childbirth.

5. Our Department officials have not formulated any official understanding of the public policy of our State as expressed by the courts and legislature as to the preference between childbirth and abortion.

6. We do not have any information as to any correlation between abortion and any of the factors described in your question #6.

7. Our response is the same for these questions as for question #6.

8. Our agency does not have anyone responsible for research or data collection about abortion, its inducements, or consequences.

9. If a woman approached our agency with a pregnancy-related problem, we would only offer services to assist her if the problem also involved mental illness, developmental disabilities, or alcohol or drug abuse.

Please contact me if you wish to have additional information on this issue and I will refer you to an appropriate person in each of our divisions.

10. We make it clear to our clients that we would try to provide appropriate support services so that a client could care for her child if at all possible. Otherwise, we would work with the appropriate agencies on adoption or other short or long-term custody alternatives.

11. We would be interested in doing more in preventing serious mental illness, developmental disabilities, and alcohol or drug abuse if given the resources to do so. However, our agency believes the greatest needs are for people with severe problems and without the resources to find appropriate services.

12. We believe that our policies and practices support employees who are pregnant so that job conditions or interruption of employment opportunities do not become a factor inducing abortion over childbirth. We provide sick leave benefits to expectant mothers who are pregnant or having problems during pregnancy preventing them from working. If accumulated sick leave benefits are not sufficient, we will provide a leave of absence so that the employee may return to work when able to do so. Moreover, we make changes in job assignments to support employees who are pregnant depending upon doctor's recommendations. Finally, we offer flex-time or part-time employment under certain circumstances as requested in support of employees while they are pregnant.

As to the questions specific to our Department:

1. Our Department does not have any information on "post-abortion stress syndrome." Such a diagnosis is not listed in the latest edition of the Diagnosis and Statistical Manual III.

2. We do not have any information on the impact of abortion on siblings.

3. We do not have any information aggregated on any of our patients who may have had a history of abortion. Such information may be in certain individual client files, but we have no way of finding that out unless all files of approximately 80,000 persons were to be examined.

4. We do not believe that any residents of DMH institutions have had abortions since 1973 while under DMH care and custody. Our Department has had a long-standing policy that our clinicians do not perform abortions.

5. Our Department obtains obstetrics and gynecology consultation for any prenatal care necessary for pregnant residents in our facilities. Such care is individually planned for and addressed depending on the needs of the clients.

6. Our Department is developing a special prenatal care program for pregnant women experiencing drug abuse problems. However, our Department does not provide any such special program now although we seek medical care and treatment for pregnant women experiencing drug abuse problems at the time they are admitted or while they are inpatients, outpatients, or in our community placement programs.

7. We provide services to pregnant women experiencing mental health problems but none are specialized. The condition of pregnancy is taken into consideration just as any other health condition.

Please do not hesitate to contact me if you wish to comment upon or respond to our answers to your questions.

Most sincerely,

Reginald H. Turnbull
Deputy Director for
Human Resources

RHT:skc
cc: Keith Schafer
John Twiehaus
Gary Sluyter, Ph.D., M.P.H.
Lois Olson
Chuck Miller
Rich McClure

Missouri

John Ashcroft, Governor

DEPARTMENT OF CORRECTIONS AND HUMAN RESOURCES

Dick D. Moore, Director

P.O. Box 236
Jefferson City, Missouri 65102
314-751-2389

November 3, 1989

Governor's Task Force
c/o Louis C. DeFeo, Jr.
P. O.Box 1022
Jefferson City, Missouri 65102

Dear Mr. DeFeo:

I have attached our response to your inquiry referencing the Health of Mothers and Unborn Children. I am also designating Division Director Myrna Trickey to attend your November 16 public meeting (751-2389).

Please feel free to contact me if any further information is necessary.

Sincerely,

Dick D. Moore
Director

DDM:MET/mrb

Attachment

cc: Myrna Trickey

QUESTIONS AND ANSWERS
Governor's Task Force on the Health of Mothers and Unborn Children

Questions to All Agencies

1. What information does your agency have on women who are experiencing problems during pregnancy?

The facilities housing female inmates do not have any information regarding women who are experiencing problems during pregnancy. All females entering the system are checked for pregnancy and venereal disease. The greater majority that are pregnant upon arrival have never received any prenatal care. This is complicated by histories od drug abuse and, in general, poor health habits. Pregnant inmates are referred to the OB-Gyn physician within two weeks. This is expedited if the inmate is experiencing pregnancy-related problems or if the inmate is considered high risk. These individuals may be seen within 24 hours.

2. What information does your agency have on abortion?

Neither C.C.C. or FRDC have information available regarding abortion.

3. What information does your agency have on the consequences of abortion in our state?

Neither C.C.C. or FRDC have information available regarding the consequences of abortion.

4. What support services or programs does your agency provide or have knowledge of for pregnant women or their children to remove inducements or duress toward choosing abortion instead of childbirth?

Our agency does not induce inmates in any manner regarding childbirth or abortion.

The abortions previously performed were done at the inmate's request. This service was never offered or volunteered. Since the Webster decision, no abortions are performed, even if requested by the inmate. When abortions were performed, this was paid for by the inmate. The only role assumed by the Department was transportation and security.

5. What is your understanding of the public policy of our state as expressed by the courts and legislature as to the preference between childbirth and abortion?

It is our understanding that the state prefers childbirth.

6. What information do you have as to any correlation between abortion and any of the following: school dropout, mental health problems, unemployment, poor health, substance abuse, imprisonment of woman or spouse, welfare dependency, lack of health insurance, family dysfunction?

In our limited experience, it appears that there is a high correlation to the conditions listed in the question.

7. Do any of the above factors induce women to choose abortion over childbirth? What other factors induce women to choose abortion rather than childbirth?

Yes, some of these factors have induced our females to consider abortion. Other items noted in our experiences are marital status of mother and possible genetic problems.

8. Does you agency have anyone responsible for research or data collection about abortion, its inducements or consequences? If so, who?

No, there is no one responsible for the collection of this data.

9. If a woman approached your agency with a pregnancy-related problem, what services would your agency have to assist her? How are these services made known to those with potential need? Who is in charge of these services?

Pregnancy-related problems would be referred to the OB-Gyn physician. Stress-related problems would be referred to the institutional psychologist.

10. If a person (client, inmate, resident, etc.) under the care, custody or control of your agency seeks an abortion, what services do you provide her as to alternatives such as adoption?

Even if one of our inmates requests an abortion, this referral is denied at this time due to the Webster decision.

11. What additional substantive legislative authority would be beneficial to your agency in expanding services to women experiencing problems during pregnancy?

We would appreciate a ruling from the Attorney General's office regarding inmates seeking abortions. Who would pay for these services? Can we participate in even a security or transportation capacity?

12. What policies and practices does your agency have to support your employees who are pregnant so that job conditions or interruption of employment opportunities do not become a factor inducing abortion over childbirth?

There are no policies. The Department does allow such leave and annual leave which totals six weeks of paid leave per year. There are also several health insurance programs which would assist with accrued medical costs.

Questions to Department of Corrections.

1. What are the policies and programs of the state for women in prison regarding prenatal care, delivery, care and custody of infant after birth, and abortion referral?

The pregnant inmates are referred promptly to an OB-Gyn physician. The physician's orders regarding activity, lab work, medications and appointments are strictly followed. Delivery is provided at Callaway Hospital or Hedrick Medical Center. The care and custody of the baby is determined by the inmate. Either a family member claims the baby at the hospital or the case is referred to Family Services where adoption will occur. There is no referral for abortion, and there never has been a referral for this.

2. How many inmates of Mo. correctional institutions have had abortions per year since 1973? Age? Location? Martial status? Multiple abortion? Month of pregnancy? What factors induced the inmates to decide on abortion?

This information has not been kept at any one source. It has been obtained from the Health Care Supervisors at C.C.C. at FRDC. Abortion was considered only if requested by the inmate. The inmate was then able to communicate with Planned Parenthood in Kansas City. It was her responsibility for financial arrangements. We provided transportation and security. We no longer provide this, even if requested. This information on the statistics was obtained from the memory of staff and may or may not be accurate. The abortions were performed at the Kansas City Planned Parenthood Clinic.

Institution	Age	Marital Status	Multiple Abortion	Month
CCC	approx 33	single	first	1st trimester
CCC	approx 25	single	first	1st trimester
FRDC	mid 20's	single	second	1st trimester
FRDC	mid 20's	single	second	1st trimester

The factors inducing the decision of abortion were as follows:

Single, high risk due to obesity
Feared abnormal baby -- father had many physical problems
Single, not wanted, no means of support
Single, not wanted, no means of support

3. Describe prenatal care services available for inmates.

Prenatal care is provided as ordered by physician. Inmates are transported to all requested appointments. All physician orders regarding activity, medication and lab work are followed.

Special housing assignments are given when the delivery date is near or if problems exist. This may be in an area close to the Medical Unit or within the Unit itself.

4. Describe services or programs provided by DOC for pregnant women to promote or support the choice of childbirth.

There are no services or programs available for this.

5. Does DOC have information on abortions by spouses of male inmates?

This information is not available.

JOHN ASHCROFT
GOVERNOR

MISSOURI
DEPARTMENT OF SOCIAL SERVICES
P.O. BOX 1527
BROADWAY STATE OFFICE BUILDING
JEFFERSON CITY
65102-1527

GARY J. STANGLER
DIRECTOR

November 2, 1989

Mr. Louis C. DeFeo, Jr.
Governor's Task Force on Health of
Mothers and Unborn Children
Governor's Office
State Capitol Building
Jefferson City, MO 65102

Dear Mr. DeFeo:

I am responding to your October 17, 1989, letter requesting information regarding the Governor's Task Force on Health of Mothers and Unborn Children. If additional information is needed, I suggest you direct your questions regarding income maintenance programs to:

Greg Vadner, Deputy Director, Income Maintenance
Division of Family Services
751-3124

Questions regarding Children's Services programs should be directed to:

Melody Emmert, Deputy Director, Children's Services
Division of Family Services
751-2882

Specific questions about the Medicaid program can be addressed to:

Donna Checkett, Director
Division of Medical Services
751-3425

I have asked Bill Siedhoff, Deputy Director, to attend the November 16 meeting of the task force on my behalf. If I can be of further assistance, please let me know.

Sincerely,

Gary J. Stangler
Director

GJS/lb
Enclosure

QUESTIONS TO ALL AGENCIES:

1. What information does your agency have on women who are experiencing problems during pregnancy?

The Department of Social Services does not maintain data specifically related to problem pregnancies. However, our programs are designed to help alleviate some of the conditions you defined as "problems during pregnancy".

For pregnant women unable to pay for medical care, they may be eligible for the Unborn Assistance Program, which provides Medicaid coverage to pregnant women with family income and resources at or below AFDC eligibility levels. In FY 89 the average number of eligibles per month was 2,162.

2. What information does your agency have on abortion?

The only instance in which the Department of Social Services would become directly involved in abortion is payment through the Medicaid program for a therapeutic abortion, i.e. one designed to preserve the life of the mother. This is an extremely rare occurrence. Only one therapeutic abortion was covered by Medicaid in FY 89.

3. What information does your agency have on the consequences of abortion in our state?

The Department of Social Services is not involved in researching or compiling this type of data.

4. What support services or programs does your agency provide or have knowledge of for pregnant women or their children to remove inducements or duress toward choosing abortion instead of child birth?

The services of the Department of Social Services are available to all women regardless of their views on abortion or the outcome of their pregnancies. We do, however, offer several programs that provide financial assistance and support services to women during pregnancy.

Programs that provide financial assistance and/or medical care include:

- Aid to Families with Dependent Children (AFDC)
- AFDC-Unborn Assistance
- Medical Assistance for Pregnant Women and Children below the poverty level
- Food Stamps
- Low Income Home Energy Assistance Program (LIHEAP)

All these services are available by applying at the county office of the Division of Family Services (DFS) in the county where the woman resides.

In addition to the medical and income maintenance services available from DFS, the Childrens' Services Section provides Problem Pregnancy Services to any woman who is experiencing difficulties with a pregnancy and requests such service. A trained social worker will provide counseling to help the woman identify the specific problems and try to assist her with solutions. This can include referral to: DFS income maintenance programs, adoption services, and other public and private agencies for services DSS does not provide. Examples of these services would include the WIC program, a nutrituional program offered by local health departments, and Families First, a family preservation program operated by the Department of Mental Health.

5. What is your understanding of the public policy of our state as expressed by the courts and legislature as to the preference between birth and abortion?

Our interpretation of the statute is that it deals with funding issues and does not state a preference for either childbirth or abortion. Specifically, it prohibits public financing of abortions, except where the mother's life is endangered, and the use of public funds to support abortion in other ways. In this regard, we believe the policies of the Department of Social Services are in compliance with all state and federal laws and regulations regarding abortion.

6. What information do you have as to any correlation between abortion and any of the following: school dropout, mental health problems, unemployment, poor health, substance abuse, imprisonment of woman or spouse, welfare dependency, lack of health insurance, family dysfunction?

The Department of Social Services has not compiled any data that would support the existence of a correlation between abortion and any of the problems you have listed. We do know, however, that many of the problems you list are consequences of early child bearing. Teenagers that have babies are more likely to drop out of school; to be unemployed; to become divorced or separated, if married; and to be dependent upon welfare. I have enclosed a copy a report prepared by the Governor's Interagency Working Group on Adolescent Pregnancy in 1987 which discusses these issues in more detail.

7. Do any of the above factors induce women to choose abortion over child birth? What other factors induce women to choose abortion rather than child birth?

The Department of Social Services has not done any research that would identify the factors that influence a woman to terminate a pregnancy or to carry the pregnancy to term. Each woman's decision is undoubtedly influenced by a multitude of moral, economic, and psychosocial factors relevant to her individual situation.

8. Does your agency have anyone responsible for research or data collection about abortion, its inducements or consequences? If so, who?

No.

9. If a woman approached your agency with a pregnancy related problem, what services would your agency have to assist her? How are these services made known to those with potential need? Who is in charge of these services?

Services available from the Department of Social Services include:

- Aid to Families with Dependent Children (AFDC)
- AFDC-Unborn Assistance
- Medical Assistance for Pregnant Women and Children below the poverty level
- Food Stamps
- Low Income Home Energy Assistance Program (LIHEAP)
- Problem Pregnancy Services, including counseling, information and referral services, and adoption

The Division of Family Services works to ensure that medical care providers are aware of the services that it provides. Hospital social work staff are generally familiar with the assistance programs available so that they can make referrals to DFS if a pregnant woman has no medical insurance or needs other types of assistance related to her pregnancy. In addition, DFS income eligibility staff are located in several major hospitals and can take applications for Medical assistance while the person is hospitalized.

The Division of Family Services also conducts a Food Stamp outreach program.

Division of Family Services financial assistance programs are the responsibility of Greg Vadner, Deputy Director for Income Maintenance.

Problem pregnancy and adoption services are directed by Melody Emmert, Deputy Director for Children's Services.

10. If a person (client, inmate, resident etc.) under the care, custody or control of your agency seeks an abortion, what services do you provide as to alternatives such as adoption?

This situation could arise in regard to females in the custody of the Division of Family Services or the Division of Youth Services.

A pregnant girl in the custody of the Division of Family Services would receive counseling primarily from the Social Service Worker assigned to her case. The Social Service Worker would counsel the girl as to all the options available to her and the consequences of each. The Division of Family Services would provide all necessary medical care throughout the pregnancy since all children in the custody of DFS have Medicaid coverage. In some instances a girl and her baby have been placed together in a foster home. The Division of Family Services can also provide adoption services, if the mother desires.

It is unlikely that the courts would knowingly commit a pregnant teenager to the custody of the Division of Youth Services, since DYS programs are not generally designed to accommodate this type of situation. In the case of the parks camps, for instance, the program is physically demanding, involving hiking and other outdoor activities. If it was later learned after commitment that a girl was pregnant, she would receive counseling from a Youth Specialist, Group Leader, or Aftercare Worker, depending upon what DYS program the girl was in. The counselor would help the girl examine her options and develop a plan. In most cases, DYS would attempt to return a pregnant teen to her home or other more appropriate facility. Only in rare instances, would a girl remain in DYS custody until delivery.

11. What additional substantive legislative authority would be beneficial to your agency in expanding services to women experiencing problems during pregnancy?

Under federal law, the state has the option of expanding Medicaid coverage to pregnant women and children under the age of one up to 185% of poverty. Implementing this program would require legislative authority and greatly increased funding.

Another federal option available for the Medicaid program, which some believe would make medical care more readily available to pregnant women, is "presumptive eligibility". Under this option, applications for Medicaid can be taken at the time of a woman's first visit to a prenatal clinic. If she meets income guidelines, she is presumed eligible and can begin receiving services immediately. This temporary eligibility period is effective for a maximum of 45 days, until a full eligibility determination can be made. Legislation to authorize such a program was introduced in the last legislative session, but did not pass (SB 174).

Presently, eligibility for Medicaid is based on both income and assets. States have the option of eliminating the assets test for pregnant women. This provision was also included in SB 174, which failed last year. The fiscal note for SB 174 estimated that the elimination of the assets test would result in an additional 549 women being eligible for Medicaid.

12. What policies and practices does your agency have to support your employees who are pregnant so that job conditions or interruption of employment opportunities do not become a factor inducing abortion over childbirth?

The personnel policies of the Department of Social Services treat pregnancy like any other temporary physical disability. Employees are eligible to apply accumulated sick leave to time off associated with delivery and any medical problems related to the pregnancy. In addition, upon a physician's recommendation, reasonable accommodations can be made in working conditions. This would be no different than that made, for instance, for a male employee with back problems.

With few exceptions, it is illegal to consider an employee's gender or his or her physical condition in determining benefits or employment opportunities.

TO DEPARTMENT OF SOCIAL SERVICES:

1. If a report is made on the child abuse hotline that the parents are involved in substance abuse to the harm of the children, what action is taken, what services provided to the family? Would the same occur if the child was preborn (in utero)?

A report of alcohol or drug abuse by a parent is not considered an appropriate report per se, unless the reporter can relate specific information as to how the child is negatively affected. Where there is an allegation that the child has been abused or neglected, the report will be accepted and investigated. The steps in the investigation process are:

- The report is relayed from the Central Registry Unit to the appropriate county office.
- The investigation by the local Social Service Worker must begin within 24 hours by seeing the child (sooner in the case of emergencies).
- The investigation must be completed within 30 days.
- The investigative worker must make a conclusion as to whether there is reason to suspect the allegations in the report are true or the report is unsubstantiated.

- o If the allegations are founded, the case will be referred for services. A case plan will be developed with the family. Services can include case management, family preservation, evaluation and diagnosis, counseling, therapeutic day care, family therapy, homemaker services, parent aide, respite care, resource coordination, and transportation. When the safety of the child in the home cannot be assured, a referral will be made to the juvenile court for placement in foster care or residential treatment.

A report involving an unborn fetus is not accepted as an appropriate report. When such a report is received by the Hotline, the caller is advised to call back when the child is born, if the problem still exists and is affecting the child.

2. If a report is made on the hotline that a minor child is under duress to have an abortion what action is taken?

The child abuse reporting statute (Section 210.110) defines abuse as:

> "... any physical injury, sexual abuse, or emotional abuse inflicted on a child other than by accidental means by those responsible for his care, custody, and control except that discipline including spanking, administered in a reasonable manner shall not be construed to be abuse."

Neglect is defined as:

> ". . .failure to provide, by those responsible for the care, custody, and control of the child, the proper or necessary support, education as required by law, nutrition or medical, surgical, or any other care necessary for his well-being."

It does not appear that the situation, as you present it, would generally fit under either of these definitions, and, therefore, would not constitute an acceptable report.

The Division of Family Services does accept reports of emotional maltreatment. Policy limits this type of report to behavior that "negatively affects and/or handicaps a child emotionally, psychologically, physically, intellectually, socially, and/or developmentally." The parent's behavior must cause emotional or mental injury to the child, which is expected to permanently impair the child's ability to function normally. It is possible that under this definition we could accept a report of extreme duress and would conduct an investigation as appropriate and offer services to the family to help ensure the child's well being.

3. What state-subsidized health clinics or other facilities or programs are available in Missouri to indigent women for prenatal care, delivery and pediatric care? Indicate locations.

Through the Medicaid program, the Department of Social Services provides medical care throughout the state to eligible individuals. Many doctors, clinics, and hospitals in the state are enrolled Medicaid providers and will accept the Medicaid card as payment for services.

With respect to the location of all hospitals and clinics in the state, you should contact the Department of Health.

4. What are the policies and programs of the state for women in prison regarding prenatal care, delivery, care and custody of infant after birth, and abortion referral?

You should direct this question to the Department of Corrections and Human Resources.

5. What programs are available to indigent pregnant women and mothers who have serious stress related problems that could lead to child abuse? i.e. short-term counseling and treatment.

The Division of Family Services operates the Parental Stress Hotline (1-800-367-2543). Callers to the Hotline can receive information about appropriate resources in their communities or can just talk to the social worker taking the call. In addition, if the caller requests a referral to the local county office or contacts a DFS county office directly, a case can be opened for "safekeeping". Under this program, no child abuse or neglect report is made; however, at the family's request, they can receive all the services normally available in protective services cases, including Children's Treatment and Family Preservation Services.

6. Is there any policy regarding private hospitals that (1) refuse Medicaid patients, (2) will accept Medicaid patients for delivery but have no prenatal clinics and make no effort or refuse to refer Medicaid patients to a doctor on staff for prenatal care?

Neither public nor private hospitals are required to be enrolled in the Medicaid program. Public hospitals that treat large numbers of Medicaid patients receive additional reimbursement through the disproportionate share program.

Private hospitals that are enrolled Medicaid providers can, and in some instances do, limit the number of Medicaid patients they will accept or the services they offer under the Medicaid program. There is no state or federal policy that prevents this.

We do not fully understand the second part of your question. With the exception of teaching hospitals, few hospitals operate their own prenatal clinics. Furthermore, if a woman presents herself at a hospital for delivery without an admitting physician and without having had prenatal care, the issue of a referral to a prenatal clinic is not relevant at that point.

As to the propriety or legality of a hospital refusing treatment to any patient, regardless of the method of payment, you should contact the Department of Health.

7. What programs are currently being offered in Missouri for treatment and follow-up counseling after treatment for drug dependent pregnant women? Are there any plans for additional programs?

The Department of Social Services does not operate any drug abuse treatment programs. These are operated by hospitals and by the Department of Mental Health, Division of Alcohol and Drug Abuse, to whom you should direct this question.

The Department of Social Services does pay for drug abuse treatment for Medicaid eligible individuals. We are presently evaluating the cost effectiveness and efficacy of such treatment, especially with respect to repeat admissions.

8. State the data available regarding drug affected babies including the children of the homeless?

We know of no source of comprehensive statewide data on this issue, which we believe to be a growing problem. The Department of Social Services is involved in this problem in two ways:

- Through the Medicaid program, the Division of Medical Services is responsible for many of the costs involved in treating these babies.
- The medical problems of a drug affected baby may make it impossible for the parent to care for the child, especially if the mother's own drug problem remains untreated. Often these babies wind up in foster homes under the jurisdiction of the Division of Family Services.

Our Medicaid payment system has diagnosis codes that indicate illnesses related to drug or alcohol abuse by adults. However, for babies that are drug affected, the only diagnosis may be neurological problems, prematurity, low birth weight, or associated problems. This makes it difficult for us to track accurately all instances of drug affected babies. In addition, some hospitals have been resistant to devoting the resources necessary to track this data outside of their normal reporting systems.

We have no medical data specifically about homeless children.

9. What programs does the state have available for pregnant women and new mothers to finish education, get job training, get employment, take parenting classes? Where are the programs located? Is child care included in the program?

There are several programs available for women who need assistance with completing their education or with job training.

- The Department of Social Services, Division of Family Services presently has two Learnfare/Welfare-to-Work pilot projects operating in the St. Louis City and Kansas City areas. Both offer adult basic education classes and job training to recipients of AFDC. Persons enrolled in these programs are given day care assistance. Planning is underway to expand this program to most areas of the state under the provisions of the federal Family Support Act of 1988 (Welfare Reform).

- The Department of Economic Development, Division of Job Training runs training programs statewide through local Community Action Agencies and Local Job Service Offices. Information on programs available in specific areas can be obtained from any of those agencies.

- The Department of Elementary and Secondary Education, Division of Vocational and Adult Education conducts adult basic education classes and runs job skills training programs throughout the state in cooperation with local school districts.

10. What is being done about the type of situation described as follows: AFDC recipient wishes to get more education or training -- goes to school through government grant -- gets low paying job (not enough to support child or children) -- AFDC and food stamps are cut -- educational grant even counted against her benefits. She must quit job and return to AFDC.

Under the new JOBS program, authorized by the federal Family Support Act of 1988 and to be operated by the Division of Family Services, participants will be reimbursed for day care and some out-of-pocket expenses related to school attendance or job training. This will not be counted against their AFDC grants.

Effective April 1, 1990, any AFDC recipient whose case is closed due to employment will be eligible for up to one year of transitional child care assistance and Medicaid after the case is closed.

11. What is currently available in Missouri in the way of state subsidized child care especially for infants? Are there any efforts in offering or expanding incentives to private entities to get more affordable child care <u>especially for infants</u> for poor women?

The Division of Family Services provides state subsidized day care under two programs:

- Income maintenance (IM) day care for recipients of AFDC, and
- Income eligible (IE) day care for other low income families.

To be eligible, parents must be either:

- employed,
- attending GED classes,
- attending regular high school classes,
- participating in an evaluation program to assess trainability or employability,
- participating in a job training program, or
- attending college.

Total spending for these two programs was $12,265,997 in FY 89; $13,720,000 has been appropriated for FY 90. In FY 89 an average of 8,156 children received day care services each month.

In applying for services, no distinction is made with respect to the age of the child, however, the reimbursement rate for care is higher for children under age two.

There has been much recent activity at the federal level aimed at providing additional day care assistance to low income families either through tax credits or direct subsidies, however, no final resolution has been made pending passage of the Omnibus Reconciliation Act.

The Missouri Child Care Development Act (HCS for SB 241) was enacted in the 1989 legislative session. It requires the Department of Social Services (DSS) to hold public hearings in 1990 and 1991 and to, "Develop a plan designed to meet the need for child care services within the state for eligible children (i.e. low income children), including infants, preschool children and school-age children, and shall make recommendations for possible changes in the state's tax structure in regards to child care, including but not limited to, child care tax credits and dependent exemptions."

In addition, the Act:

- requires DSS to coordinate child care services with other state, local, and federal programs;

- o requires DSS to train AFDC recipients as day care providers, if funds are available;

- o requires all Division of Family Services licensing staff be trained in child care and development;

- o requires DSS to conduct a consumer education program designed to inform parents and the general public about licensing requirements and complaint procedures; and

- o creates the Child Care Advisory Committee to review the current status of child care across the state to outline deficiencies and make recommendations to the general assembly and the governor.

There have been various bills introduced, including SB 542 last year, to provide a tax credit for businesses that provide day care facilities for the dependent children of their employees, but none has passed so far.

In addition to the day care programs discussed above, the Division of Family Services provides protective services day care as part of Children's Treatment Services. This program provides therapeutic day care to children residing in their own homes or in foster homes as part of a casework plan to help remedy abuse or neglect. Children can receive this type of day care without regard to their parents' income.

12. What is the status of legislation on child support enforcement to bring Missouri into compliance with federal regulations? What are current Missouri policies? How is child support enforcement being implemented as far as AFDC recipients?

The federal Family Support Act of 1988 required several changes with respect to the establishment and collection of child support obligations. Those provisions and the current status are listed below:

- o Courts must use uniform guidelines, i.e. the same financial guidelines would apply to all cases equally, for establishing the amount of child support obligations. Status: The legislation necessary to establish these guidelines was passed during the last legislative session (HB 2).

- o By November 1, 1990, states must have laws requiring parents to furnish their Social Security Numbers to the state at the time of a child's birth. Status: This provision was deleted from child support legislation passed last year. It will be introduced again this year.

- o By November 1, 1990, states must have laws requiring immediate wage withholding to meet child support obligations for all IV-D (AFDC) cases. Also, by January 1,

1994, immediate wage withholding must be included in all child support orders--not just IV-D cases. Status: Implementing legislation is being proposed in the upcoming legislative session.

- Each state is required to have a statewide, automated monitoring and tracking system for all child support awards and payments in place and operating by January 1, 1995. Status: Implementing legislation is being proposed in the next legislative session.

Missouri's child support enforcement program is required by law to provide equal access to services for both AFDC clients and non-AFDC clients. I have enclosed a pamphlet, "What's this about Child Support," that briefly outlines those services.

With respect to AFDC recipients, it is a condition of eligibility that the applicant assign to the state all rights to support from another person for any family member for whom assistance is requested or to whom payments will be made. In this way, the absent parent makes support payments through the child support enforcement agency, not directly to the custodial parent. If the support payment exceeds the AFDC grant, it is generally more advantageous for the family to request the AFDC case be closed and receive the full amount of the child support payments.

13. Adoption: How many babies are available for adoption per year under the Division of Family Services? How many are adopted? What is the reason some are not adopted? What happens to those not adopted? How many are infants? What is the policy of DFS regarding placement for adoption of minority children with white adoptive families?

Because of the way the computer data base is structured, we cannot retrospectively determine the number of babies that were available for adoption within a given year. We can, however, tell you the number of children that were adopted and the number of children currently available for adoption.

The number of young children adopted in the past several years is shown on the table below:

Age	1985	1986	1987	1988
Under 1 year	47	35	27	25
1 year	69	81	84	58
2 years	40	48	43	42
3 years	40	50	53	55
Over 3 years	373	371	359	362
Total	569	585	566	542

As of October 1, 1989, 372 children in DFS custody were awaiting adoption. Of these, 28 are under one year of age; 9 are one year old; 11 are two years old; 11 are three years old and 313 are over three years of age.

Children of minority racial or ethnic heritage, who have physical or mental handicaps, or who are members of a sibling group needing placement together are considered to have special needs. Special needs such as these could cause it to take longer to find an appropriate family to meet the child's needs, however, only in very rare circumstances would DFS be unable to place a young child for adoption within a reasonable length of time. DFS has experienced much success through its recruitment efforts even in placing severely handicapped young children. Children available for adoption generally remain in foster care until a adoptive home is found. Only in rare instances would a young child be placed in a residential facility pending adoption.

It is the policy of the Division of Family Services to consider the child's need to integrate his ethnic, cultural and religious background into his new life with an adoptive family. However, current policy prohibits any restrictions on the selection of an adoptive family for a child solely for reasons of ethnic and cultural background. DFS policy prohibits delaying the placement of a child for adoption for the single reason that a family of similar ethnic and cultural characteristics is not available. There is also a specific prohibition against removing a child from a foster family, who wishes to adopt the child, based solely on the reason that the foster family is of a dissimilar ethic and cultural background.

COCAINE USE AND PREGNANCY

Cocaine use during pregnancy is of great concern at this time because the incidence of drug addicted mothers appears to be definitely on the increase. A recent study in Boston [2] followed 1226 urban women enrolled in prenatal care. Of these, 18% were found to have used cocaine at least once during pregnancy, and 9% had urine assays positive for cocaine metabolites.

In the Springfield area, local neonatologists have noted a rising increase of cocaine addicted babies, and mothers who have used drugs. This has also been an increasing problem to the Juvenile Court of Greene County.[10] In fact, throughout the country this is a very significant problem, and a very definite increase has been noted over the years of 1985 to 1988.

Numerous studies now have determined the effects of cocaine on newborns. In general, these studies note an increase in prematurity, lower birth weights, and an increase in central nervous system irritability. A study from Chicago[5] noted a significant impairment of orientation, motor, and state regulation behaviors as assessed by the Brazelton neonatal behavior assessment scale. Another study from California[4] noted that 26% of these babies had mild withdrawal symptoms, 6% needed treatment. All of the babies had altered neonatal behavior patterns with abnormal sleep, poor feeding, tremors, and hypertonia. In another study from California[1], 21.4% of these babies were noted to have microcephaly, and 26.7% had intrauterine growth retardation. There is also a higher incidence of placental hemmorhage, and 60% of women using cocaine in a study from New York[9] had received no prenatal care. All of these circumstances are likely to cause long term, permanent problems, and probably result in an increase of mental retardation and school performance problems.

What this amounts to is an epidemic of drug use, causing permanent impairment to newborn infants. This is a relatively recent problem, really just surfacing since 1985, so the response throughout our country has been limited and varied. A judge in Washington DC[11] sentenced a mother to jail because she would not quit using cocaine. In the State of Missouri, at present, there are no laws that specifically pertain to this problem. It has also been shown that drug addiction during and after pregnancy substantially increases the risk of child abuse. Approximately 30% of child abuse cases do involve a household in which drugs are being abused.[10] Yet, Missouri law does not yet consider drug abuse during pregnancy to be evidence of child abuse.

For all of these reasons, therefore, it is most important and pertinent to try to do something about cocaine and drug addiction in our society. I have no statistics available, but one would suspect these mothers would be more likely to seek abortion services, and be less responsible in obtaining prenatal care or contraception. These babies also will probably be difficult to place for adoption because of the associated increase in microcephaly and behavior problems. I have, therefore, raised the following questions:

1) Drug addiction during and after pregnancy has shown to sub-substantially increase the risk of child abuse. In the State of Missouri, what services are available to these families? Does the Child Abuse Hot Line apply to these situations? What numbers of children reported for child abuse have been found to live in drug addicted households?

2) What social services are currently offered drug addicted mothers?

3) What treatment programs are available to drug addicted mothers in the State of Missouri?

Submitted by:

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November 10, 1989

BIBLIOGRAPHY

1. "Maternal Cocaine Use During Pregnancy: Effect on the Newborn Infant" Pediatrics (Vol. 84, No. 2, August 1989), pp. 205-210.

2. "Effects of Maternal Marijuana and Cocaine Use on Fetal Growth" The New England Journal of Medicine (Vol. 320, No. 12, March 1989), pp. 762-768.

3. "Perinatal Cocaine and Methamphetamine Exposure: Maternal and Neonatal Correlates" The Journal of Pediatrics (Vol. 111, No. 4, October 1987), pp. 571-578.

4. "Perinatal Outcome of Infants Exposed to Cocaine and/or Heroin In Utero" AJDC (Vol. 143, August 1989), pp. 905-910.

5. "Cocaine Use During Pregnancy: Adverse Perinatal Outcome" American Journal of Obstetrics and Gynecology (Vol. 157, No. 3, September 1987), pp. 686-690.

6. "Temporal Patterns of Cocaine Use in Pregnancy" JAMA (Vol. 261, No. 12, March 1989), pp. 1741-1744.

7. "Cocaine Abuse During Pregnancy: Maternal and Fetal Implications" Obstetrics and Gynecology (Vol. 73, No. 2, February 1989), pp. 157-160.

8. "Neonatal Neurologic and Electroencephalographic Effects of Intrauterine Cocaine Exposure" The Journal of Pediatrics (Vol. 113, No. 2, August 1988) pp. 354-358.

9. "A Cohort Study of Alkaloidal Cocaine ("Crack") in Pregnancy" Obstetrics and Gynecology (Vol. 72, No. 2, August 1988), pp. 147-151.

10. Panel discussion and talk to the OB/GYN and Pediatric Department Meeting of St. John's Regional Health Center, Springfield, Missouri, on September 19, 1989. Featuring Perry Epperly of the Juvenile Court of Greene County, and Tom Mountjoy, Prosecuting Attorney of Greene County, Missouri.

11. "Close to Home" Washington Post (September 4, 1988).

FOCUS...

Care in Missouri

Infant mortality and its leading cause, low birth weight, are serious public health problems in the United States. Research has shown that women who receive adequate prenatal care during their pregnancies have much lower rates of low birth weight infants than do women who receive less than adequate prenatal care. In Missouri, inadequate prenatal care[1] has been identified as a significant factor for women whose babies die in the neonatal period[2], which is mostly associated with low birth weight.

As with infant mortality and low birth weight which remain much higher among nonwhites than among whites, there are racial disparities which exist in prenatal care utilization rates. The inadequate prenatal care rate in Missouri (1987) was 16.5 percent, but was 13.4 percent for whites and 31.0 percent for nonwhites.

Because of the association between prenatal care and positive pregnancy outcome, there has been a great deal of interest in identifying the barriers to prenatal care, in order to eliminate them and enable all women to obtain early and continuous prenatal care services. A study co-sponsored by the Missouri Perinatal Association and the Missouri Department of Health was undertaken to identify both the barriers and inducements to receiving early and continuous prenatal care services.

The study was conducted in Kansas City, St. Louis and Southeast Missouri, as these have been identified as the areas with the highest rates of infant mortality and inadequate prenatal care in Missouri. Face-to-face interviews were conducted with postpartum mothers prior to discharge in 11 hospitals. Interviewers determined whether women had adequate or inadequate care based on the prenatal record or from the patient herself, and conducted interviews with women who received inadequate prenatal care and an equal number of adequate-care mothers. Interviews began in June, 1987 and were completed in Kansas City and St. Louis in September, 1987. Because of the smaller number of births, interviews in Southeast Missouri were completed in June, 1988.

In the urban areas, the study was conducted primarily in large, public hospitals which serve primarily low-income and minority women. Because of this, the two groups of women (those who received adequate or inadequate care) were drawn from approximately the same population. In Southeast Missouri although the hospitals served both "public" and "private" patients, the two groups were comparable in their representation of adequacy of care.

After matching the questionnaires with birth certificates, there were a total of 1,484 women, 764 (51.5 percent) of whom had inadequate prenatal care. Table 1 illustrates the adequate and inadequate prenatal care populations by selected characteristics. As expected, the two groups were differentiated by race, age, marital status, education, gravidity and income. The inadequate prenatal care group had a higher percentage of black, teenage, unmarried, less educated, high parity and low income (less than $5,000/year) women than did the adequate care group. The inadequate care group had more Medicaid participants (55.4 percent) and Food Stamp participants (41.0 percent) than the adequate care group (Medicaid: 40.3 percent, Food Stamps: 33.1 percent). On the other hand, the adequate care group had a higher rate of WIC participants (74.9 percent) than the inadequate care group (65.6 percent). The inadequate care group had higher rates of women with no previous source of health care (60.2 percent) than the adequate care group (50.6 percent) but had lower rates of women who worked outside the home (35.8 percent) than the adequate care group (47.2 percent). These were both direct and proxy variables for poverty which emerged as a major factor in differentiating between the two groups.

Wantedness of pregnancy was examined by a series of questions illustrated in Table 2. When asked how they felt when they found out they were pregnant, over half (54.2 percent) of those with adequate care said they were happy, while only 32.1 percent of those who received inadequate care said they were happy. The remaining wantedness of pregnancy variables each differentiated the inadequate and adequate care groups. The inadequate care group had much higher rates of women who didn't want to be pregnant, or want others to know of the pregnancy or who considered adoption or abortion than the adequate care group.

Table 3 illustrates other problems commonly thought to affect prenatal care utilization. The inadequate group reported more problems with transportation, childcare problems and financial problems affecting their ability to pay for care or find prenatal care providers than the adequate care group. Women from the inadequate care group were twice as likely (18.7 percent) to report having too many other problems to go for care than those in the adequate group (7.8 percent) A sizable number of women from the adequate care group (17.5 percent) and the inadequate group (22.0 percent) reported that they just didn't feel like going sometimes.

The inadequate care group reported that they experienced "a lot" of stress during pregnancy a third more often (38.6 percent) than the adequate care group (29.0 percent). Table 3 also reveals the mediating influence of social support on prenatal care utilization, as women in the adequate care group had higher rates of social support than those in the inadequate care group.

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1. Inadequate prenatal care is defined both by late entry into care (after four months of pregnancy) as well as by number of total visits (less than five visits for pregnancies less than 37 weeks, or less than eight visits for 37+ week pregnancies).

2. Pierson, V.H. (1987): Perinatal and Postneonatal Mortality and Low Birth Weight in Missouri. Missouri Center for Health Statistics Publication No. 4.33.

Table 1

Percent Distributions of Adequate Prenatal Care and Inadequate Prenatal Care Populations by Selected Characteristics

	Adequate Prenatal Care Group		*Inadequate Prenatal Care Group*	
	Number	*Percent*	*Number*	*Percent*
Black, Non-Hispanic	342	47.9	432	56.7
Age under 20 at Delivery	196	27.2	267	35.0
Unmarried at Pregnancy Onset	446	61.9	574	75.1
Less than High School Education	282	39.2	410	53.7
Number of Prior Pregnancies:				
0	262	36.4	217	28.4
1-3	397	55.1	438	57.3
4 or More	61	8.5	109	14.3
Income (Yearly):				
Less than $5,000	200	27.8	295	38.6
$5,000 - 9,999	187	26.0	171	22.4
$10,000 - 14,999	100	13.9	82	10.7
$15,000 and over	117	16.3	82	10.7
Unknown	116	16.1	134	17.5
Medicaid Participant	290	40.3	423	55.4
Food Stamp Participant	238	33.1	313	41.0
WIC Participant	539	74.9	501	65.6
No Previous Regular Source of Health Care	363	50.6	459	60.2
Worked Outside the Home During Pregnancy	339	47.2	272	35.8
Perceived Prenatal Care Very Necessary	649	90.4	553	73.0
Health Problems During Pregnancy	279	39.0	220	29.0
Total*	720	100.0	764	100.0

*Includes unknowns.

Table 2

Percent Distributions of Adequate Prenatal Care and Inadequate Prenatal Care Populations by Wantedness of Pregnancy Variables

	Adequate Prenatal Care Group		*Inadequate Prenatal Care Group*	
	Number	*Percent*	*Number*	*Percent*
Unplanned Pregnancy	516	71.9	646	84.9
Felt Happy When Learned of Pregnancy	389	54.2	244	32.1
Didn't Want Others to Know of Pregnancy	84	11.7	177	23.2
Didn't Want to Think About Being Pregnant	126	17.5	231	30.2
Didn't Know She Was Pregnant	22	3.1	148	19.4
Afraid to Tell Parents of Pregnancy	107	14.9	171	22.4
Afraid to Tell Baby's Father of Pregnancy	39	5.4	64	8.4
Wasn't Sure She Wanted to Be Pregnant	236	32.8	346	45.3
Embarrassed About Being Pregnant	41	5.7	71	9.3
Considered Adoption	24	3.3	56	7.3
Considered Abortion	85	11.8	141	18.5
Total*	720	100.0	764	100.0

*Includes unknowns.

Table 3

Percent Distribution of Adequate Prenatal Care and Inadequate Prenatal Care Populations for Selected Problems, Stress, and Support During Pregnancy

	Adequate Prenatal Care Group		*Inadequate Prenatal Care Group*	
	Number	*Percent*	*Number*	*Percent*
Transportation Problems	142	19.7	243	31.8
Childcare Problems	36	5.0	78	10.2
Too Many Other Problems to Go for Care	56	7.8	143	18.7
Just Didn't Feel Like Going Sometimes	126	17.5	168	22.0
Afraid of Medical Procedures/Doctors	23	3.2	44	5.8
Couldn't Get an Appointment Earlier	20	2.8	49	6.4
Over One-Hour Wait to See Doctor	180	25.1	212	30.6
Couldn't See What I Gained from Care	7	1.0	26	3.4
Financial Problems Regarding Care:				
Didn't Have Enough Money for Care	316	43.9	387	50.6
No Insurance Until Later in Pregnancy	83	11.5	120	15.7
Didn't Know Where to Go for Low-Cost Care	58	8.1	114	14.9
Couldn't Find Doctor Who Accepted Medicaid	3	0.4	18	2.4
Turned Away Because Couldn't Make Payment up Front	9	1.2	37	4.8
They Hassled Me About Money	6	0.8	18	2.4
Experienced "A lot" of Stress During Pregnancy	208	29.0	293	38.6
Excellent Help/Support from Baby's Father	291	40.5	234	30.9
Excellent Help/Support from Others	285	39.6	252	33.2
Total*	720	100.0	764	100.0

*Includes unknowns.

Among the factors which were examined but which had no relation to the adequacy of care were satisfaction with care, length of wait to get an appointment, stressful life events pertaining to living conditions, problems with partner or family, problems with a job, and death or illness of family members or close friends. Prenatal care in the previous pregnancy did not have any relation to adequacy of care for this pregnancy. Neither did concern about the baby's health, about the woman's own health or about factors such as school enrollment or problems with the Medicaid application process.

One of the main barriers to prenatal care is poverty, as revealed by the high percentage of Medicaid and Food Stamp participants in the inadequate prenatal care group. Medicaid-eligibility by itself will not guarantee adequate prenatal care. The additional support and educational services offered by WIC may have fostered higher rates of adequate prenatal care. While transportation and childcare problems can be addressed by clinics within the existing system, issues pertaining to poverty and to wantedness of pregnancy must be addressed by society as a whole in order to improve the rate of adequate prenatal care utilization.

MISSOURI MONTHLY VITAL STATISTICS

Provisional Statistics

FROM THE

MISSOURI DEPARTMENT OF HEALTH
STATE CENTER FOR HEALTH STATISTICS
Jefferson City, Missouri 65102-0570
(314) 751-6272

October 1988 VOL. 22 NO. 8

Missouri Department of
HEALTH

John Ashcroft
Governor

Robert Harmon, M.D.
Director

Southwestern District

1150 East Latoka
Post Office Box 777, MPO
Springfield, MO 65801 • 417/883-1555

November 3, 1989

Dr. Yvonne Bussman
3231 S. National
Springfield, MO 65807

Dear Dr. Bussman:

I apologize for the delay in getting these materials to you. I hope they will arrive in time to be helpful. Please call me if you wish clarification or if there are questions.

Sincerely,

Janie K. Vestal, MD
Medical Specialist

JKV/clm
enclosures

BARRIERS TO PRENATAL CARE IN SOUTHWEST MISSOURI

October 1989

In my own experiences in providing care to pregnant women in the Southwest Missouri District, I would like to note some of the obstacles I see in our ability to provide perinatal care to these women, their babies and their families.

1. Health Education

   Health Education is not required in Missouri schools, and many of the women we see, especially those served by small rural school districts, do not receive any basic health training in their education process. I have seen many pregnant teenagers who do not know basic human anatomy, and who know nothing about the human reproductive process. These children literally do not know how they got pregnant. Beyond this they do not know the value of obtaining prenatal care nor do they understand how to take care of their infant after it arrives: what routine health care and immunization their infant will need, why there is a reason to not smoke or drink or use substances during pregnancy. Even more concerning than this lack of basic knowledge, is the lack of sufficient training in basic life skills for these young women. They have no sense of what healthy relationships or family structures are like. They have had no instruction in developing skills related to self esteem or communication or peer resistance. And in many of their schools, basic health services such as school nursing and adequate counseling services are absent. This problem can be addressed by adopting a comprehensive school health program into our schools for children from kindergarten through the 12th grade and by expanding our community education programs.

2. Program Outreach.

   Many of our women present very late for prenatal care, often in the seventh or eighth month. When I ask them why they delayed seeking medical attention, their response is often that they do not have any money and that they were not aware of the availability of free prenatal care in their community. We must do a better job of convincing every potentially pregnant woman that it is her

right and responsibility to seek early prenatal care and provide some mechanism for making each woman aware that it is available. This applies not only to prenatal care but also to pregnancy testing and to family planning services. I believe a toll free number for location of services and a well planned media campaign could make a difference in this area.

3. Family Planning Services.

It is very difficult to motivate women to properly care for themselves when they are carrying an unwanted pregnancy.

While it is important to focus on our ability to provide perinatal care, one cannot help but to realize how an increased emphasis on family planning programs could directly lessen our problems in the perinatal realm. Family planning is the classic example of cost effective use of public health dollars, and much more attention must be paid to the accessibility, the availability, the acceptability of family planning service in each of our counties. The availability of family planning services throughout Missouri must be looked at from a state-wide perspective, taking into account coordination of State family planning clinics with Federally funding family planning efforts. Accessibility must be addressed. While a family planning clinic may exist in a county, a post partum patient may have to wait six months to be placed on the list for an appointment. Too often the need for that appointment passes before the wait, and she returns with a subsequent pregnancy. Acceptability of services is another issue. If we continue to hold our clinics during school hours so that our teenagers cannot be served, or if we hold them one time each month in small town, when everybody knows that family planning is being held at the Courthouse on Thursday afternoon, we can assure ourselves that many young women and men needing these services will not avail themselves of them.

4. Coordination of Services.

We sometimes make it very difficult for any productive member of our society to utilize public perinatal health services. We hold our clinics during regular work hours, and too often make our patients wait unreasonable amounts of time for their care. We ask women to come one day in a month for their WIC

services, and another day for their well baby services, and another day for their prenatal care. In situations where transportation is an on-going problem this only heightens the difficulty for women often struggling to manage a family with little or no support.

5. Medicaid

Medicaid expansion has been very positive for our patients. For many women it has meant that their prenatal care and delivery services have been linked. For others it has meant access to the high risk obstetrical care that they previously needed and had been unavailable to find. For those who have become Medicaid eligible yet stayed within the public health department for prenatal care, it meant that they had coverage for their delivery, for their hospital stay and for the subsequent care of their baby. While the quality of service offered by each DFS office varies from county to county as does the quality of local health service, there are many concerns which have been unanimous throughout the district.

A. The Missouri Medicaid application is unreasonably long and complex.

B. The assets (resource) test must be eliminated and eligibility throughout pregnancy must be continuous,consistent with current federal options.

C. Reimbursement rates must be more reasonable. We support the increase of the Medicaid global fee to $1,000.00. Reimbursement has been shown in our district (Springfield), and by State and National studies to be a major factor in provider participation. We feel this could prevent further loss of current providers and could encourage some new physicians to include OB in their practice.

D. The second most common reason (after reimbursement) for physicians not accepting Medicaid is that of the inefficient billing system. As our public clinics have become Medicaid providers, we have experienced the cash flow problems, returned claims, and time consuming paperwork we've heard those private practice describe for so long. There are models from other states for reforming this part of state bureaucracy, and this particular inefficiency may be costing lives as well as money.

E. Standards of care have not been incorporated into Missouri Medicaid. This means that we will reimburse any physician for prenatal care which is not subjected to any accepted (ACOG) guidelines, and allow reimbursement for women delivered at centers inappropriate to their level of risk or their infant's nursery needs.

F. Transportation is a major problem in caring for rural patients. Even if high risk care can be identified, too often we can't get the woman to the referral center. Federal Medicaid regulations provide (since 1970) that the State Medicaid plan will specify that the agency will assure necessary transportation for recipients to and from medical providers.. Those of us working in rural areas with no public transportation of any sort and no resources for our patients know this is not a reality in Missouri.

If Medicaid is to be the form of care for poor women and babies, it must be reformed in Missouri.

6. Prenatal Care and Deliveries.

If we believe that any woman seeking prenatal care in our state should be given our opportunity to have care, even in thinking populated rural areas where a traditional clinic setting is not financially advantageous, then we must make a policy-level and pocketbook level commitment to providing care. This could come in the form of expanded multi-county systems or in travelling prenatal teams to rural counties or in provision of real transportation services. Likewise, if we want to eliminate "walk-in" deliveries, we as a state must pay for delivery services in addition to prenatal care.

There can no longer be any debate about the value of prenatal care. Study after study has demonstrated it's short-term and long-term cost effectiveness, not to mention the savings in human terms.

7. Rural Access to Technology.

Provision of prenatal care is made more difficult just by provision of prenatal care in a rural area. Lab services, when supplies and

specimens must be mailed both ways, can be inaccurate and time consuming. Ultrasound services are another example of a routine prenatal need, either serviced by a mobile unit of questionable quality, or at great distances for patients.

8. Health Manpower.

The crisis of health manpower in this area of health care cannot be overstated. Several times in the past year, the loss of one nurse or one physician has thrown an entire system into jeopardy. Nurses with interest and expertise in prenatal care are rare. We must expand training to our community health nurses if universal access is ever to be a reality, and we must become more competitive employers. We simply cannot recruit Nurse Practitioners, despite nation wide searches, yet state sponsored training for these individuals is lacking. Although nurse midwives have been used elsewhere with enormous success to solve many of these problems, acceptance in this area by physicians and hospitals has impeded practice by CHN's, leaving those seeking alternative deliveries to utilize lay midwives or midwives in home or undersupervised clinic settings. And our physician providers are an increasingly fragile group. Family and general practitioners are closing their OB practices on a regular basis, often after realizing years of losses in this area of practice due to malpractice costs. While the Legal Expense Fund has served a few in this district, it provides no short term relief to wavering providers in meeting liability costs. This area of provider availability will become increasingly crucial if Medicaid eligibility increases to 185% of the Federal poverty level. Neither Medicaid nor indigent nor insured can receive good care without availability of qualified local providers. One important solution to this problem in our district is the Cox North Family Practice Residency in Springfield, which is recruiting and training physicians interested in practicing OB in rural Missouri. We must support efforts such as this one, which are attempting to answer our needs for the future.

SUMMARY OF EXISTING PRENATAL CLINICS IN SOUTHWEST MISSOURI
October 1989

There are currently 4 multi-county prenatal systems and 3 single county prenatal service systems which exist as a part of the 21 county Southwest Missouri Health District. These Prenatal Clinics vary widely in their staffing patterns, in their inter-action with the Medicaid Program, and in the needs of the patients they serve.

1. Springfield/Greene County

Although Springfield is not considered a rural area, many patients from surrounding counties utilize it as a referral center. Any medically indigent Springfield or Greene County woman seeking prenatal care may be admitted to the Springfield City Clinic for those services, currently provided by an RN level nurse and a Board Certified Family Practitioner. While this clinic admits a great number of patients, the patient load which it follows through to term is quite small (in September 1989 they were caring for a total of 54 pregnant women), which is a dramatic change from the time previous to one year ago when the clinic served a large volume of prenatal patients and when the hospitals of Springfield were inundated with large numbers of walk-in deliveries. Several occurrences over the last 1 to 2 years have brought changes which have resulted in the current situation:

A. Medicaid expansion in January of 1988 up to 100% of the federal poverty line brought increased numbers of the patients into the publicly funded prenatal system.

B. As District Physician for the Southwest District I convened for the first time in the Spring of 1988 a group called the Southwest Perinatal Health Consortium. This group is made up of Hospital and Public Health Administrators, Pediatricians, Obstetricians, Neonatologists, Family Practitioners, a Perinatologist, and Medical Society staff. We meet on a regular basis to openly communicate about problems in the perinatal arena and to problem solve around the communities need for provision of care to indigent women and babies.

C. The family practice residency at Cox North was established in 1987 and accepted its

first group of 4 residents in July of 1988, with a second group of 6 additional residents beginning in July of 1989. The residency has accepted both Medicaid and non-Medicaid indigent women into its clinic for prenatal care and delivery by family practitioners and their obstetrical faculty.

D. Up until the summer of 1988 there was only 1 obstetrician in the Springfield area accepting Medicaid clients for prenatal services in their office. With the advent of an innovative program by St. John's Regional Medical Center and Lester E. Cox Medical Centers the obstetrician worked out agreements with their delivery hospitals which provided for increased payments for physicians for Medicaid perinatal services, and also lessoned the administrative burdens of filing for Medicaid for these physicians. As a result there are currently between twenty and twenty-five obstetricians in the Springfield area who are willing to accept Medicaid patients in their office upon referral from the public health department in Springfield as well as from outlying counties.

E. High Risk Prenatal Services.

Also in the summer of 1988, Dr. Patricia Dix, MD, a perinatologist, came to the Springfield community. Dr. Dix has been willing to accept medically high risk prenatal patients who are indigent from any of our prenatal clinics, upon referral. This has allowed an increase in risk-appropriate referrals, and for maternal transport of mother's carrying high risk infants to occur antenatally, rather than encouraging the practice of transporting a critically ill neonate after the delivery has occurred.

With the above changes in place, aIl patients presenting to this clinic are referred to DFS to determine Medicaid eligibility. The vast majority receive Medicaid, and are then referred to obstetricians for the remainder of their prenatal care and delivery. Those ineligible for Medicaid remain in the clinic system, unless determined to be high-risk. Their deliveries are on a "walk-in" basis by the physician on call. The DOH prenatal program does not pay for delivery services.

2. The Southwest Regional Prenatal Clinic.

This is a 5 county cooperative effort involving Stone, Taney, Barry, McDonald and Lawrence Counties. It is administered by Lawrence County and utilizes an RN level nurse as the prenatal care coordinator. This nurse holds a weekly clinic in each county with physicians clinics held monthly at each site as well. As the District Physician, I am supplying this physician component of care in this system for 2 counties, one which has no obstetrical providers at all and one which has no Medicaid obstetrical providers. Of the 5 counties, only 1, Taney County, has a hospital which performs deliveries. Unfortunately the physicians who deliver in Skaggs Hospital in Branson do not accept Medicaid. The only other delivery site located in this 5 county area is a free-standing mid-wife clinic which is located in Barry County. All women entering this system are referred, upon presentation, to DFS for determination of Medicaid eligibility. Most women who become Medicaid eligible opt to transfer their care to a provider in Springfield, if they are able to arrange transportation. Those who do not receive Medicaid usually become "walk-in" deliveries or attempt to make arrangements for delivery-only with a physician in the area. Many of the women in McDonald and Barry County opt to cross the Arkansas line for delivery, some of them finding a physician there who will accept Missouri Medicaid. Both the family practice residency and Dr. Dix have been able to accept high risk patients referred from this clinic. The most common difficulty with this system is the lack of transportation for these patients, many of whom have to travel 2 hours or more for high risk pre-natal care and delivery.

3. Webster County.

This single county system has begun offering prenatal care for the first time this year to a limited number of clients. They are staffed by their own community health nurses as well as by a local physician, who does not deliver himself,but refers patients to Springfield providers for delivery. They refer clients for Medicaid eligibility, and, if a woman becomes eligible, transfer her out of their clinic setting into the private sector.

4. Polk County.

This single county health department receives a limited number of deliverables from the State for the provision of prenatal care. They then

contract with a local group of Board Certified family physicians who agree to provide prenatal services to these women for the State fee. This group of physicians also accepts Medicaid clients and a delivery hospital located in the county. High risk women are again referred to Springfield.

5. Lakes Area Prenatal Clinic.

This is a multi-county system serving 5 counties: St. Clair, which is the administrative county, Hickory County, Benton County, Henry County and Cedar County which has no local health department. Their prenatal care coordinator is an RN level practitioner who holds weekly clinics in St.Clair County, with Hickory County patients traveling to that site, and in Henry County, with Benton County patients traveling there. There are also outreach clinics scheduled in Appleton City which is located within St. Clair County, as well as in Stockton located in Cedar County. The Stockton clinic is staffed by the physicians from Bolivar (in Polk County), and the women for the most part go to Citizen's Memorial Hospital in Bolivar for delivery. There are 2 delivery facilities located in this 5 county area, and they are Sac Osage Hospital, located in Osceola, with 2 family practitioners delivering there; and Golden Valley Hospital, located in Clinton, with several general practitioners delivering. Because there is no obstetrician serving this area, Caesarean sections are performed by a surgeon who is based in Clinton, and high risk patients are referred either to Springfield,or to St.Lukes or Truman Medical Center in Kansas City. All of our physicians in this area accept Medicaid clients in their practice, however due to the numbers of patients needing service and the quality of care offered by this clinic, they opt for the women to receive the majority (if not all) of their prenatal care within the clinic setting and to be delivered then by physicians who staff both the clinic and the delivering hospital.

6. Midwest Missouri Prenatal Clinic.

This is a 3 county system serving Bates, Barton and Vernon County. Each of these counties is unusual in that they each have a delivering hospital. Each has delivering physicians accepting Medicaid, and each has access to the nurse practitioner who is the coordinator of this area clinic. The majority of high risk patients from this area are referred to Kansas City St.Lukes Hospital or Truman Medical

Center for additional care. Most patients in this system, including Medicaid patients, stay in the clinic setting throughout their pregnancies.

7. Joplin City Health Department.

This clinic serves the medically indigent of Joplin City as well as women from outlying Jasper and and Newton County. Until September of 1989 there was a nurse practitioner who was the coordinator of this clinic. Following her resignation this care has been provided by the community health nurses in this clinic, part time staffing by the nurse coordinator from another clinic, and the physicians who staff the health department. Although an agreement had been worked out for high risk referral from the nurse practitioner to area obstetricians, in the nurse practitioner's absence this system has failed. There are 3 delivery sites in this 2 county area, those being Sale Hospital in Neosho which accepts no Medicaid or indigent clients, Freeman in Joplin which has 6 delivering obstetricians, none of whom currently accepts Medicaid, and Oak Hill Hospital also in Joplin served by 1 obstetrician and 2 delivering general practitioners. Within the last month the obstetrician serving Oak Hill has begun accepting 1 Medicaid client weekly and the 2 general practitioners there also accept limited numbers of Medicaid patients. Due to the current staffing crisis in this clinic,which sees a large number of patients due to the lack of availability of Medicaid providers here, and because of our current inability to locate a replacing nurse practitioner or other qualified nursing staff, the future of this clinic is uncertain. The possibility of transferring the entire prenatal system into the private sector has been discussed, and in this interim time, active consultation and support are being provided by the State as this health department struggles to serve a huge volume of women who would otherwise go without care.

In addition to the above systems there are 3 other counties in the Southwest District in which there is no organized system for public prenatal care being offered. The first of these is Christian County. The staff at the local health department there refer all women identified as pregnant (either by pregnancy testing done in the health department, by telephone referrals or through their WIC clinic) to the DFS office to determine Medicaid eligibility. Each woman is assigned to a community health nurse who follows that person through the process until she has found a medical provider. That provider is usually a Springfield obstetri-

cian or family practitioner, or might be the one Medicaid provider in Christian County who accepts prenatal patients. If a non-Medicaid eligible woman is identified who is unable to locate prenatal care, the county health nurse then contacts the district physician who assists with locating a prenatal provider. The second of these counties is Dallas County. Again the nurses in this county use a similar system of directing women to the DfS office and assisting them in finding a provider. They have had good success with referring both to the Bolivar physician group and into Springfield. The final county without a prenatal clinic is Dade County,which does have a Medicaid accepting physician located in the county who does delivery in a free standing clinic setting there. Any women identified as needing prenatal care are again encouraged to seek Medicaid and then directed to a Medicaid provider, utilizing the district office as back up if they are unable to place a non-Medicaid eligible woman.

There are major implications for each of these clinics when changes in DOH funding and in Medicaid funding occur:

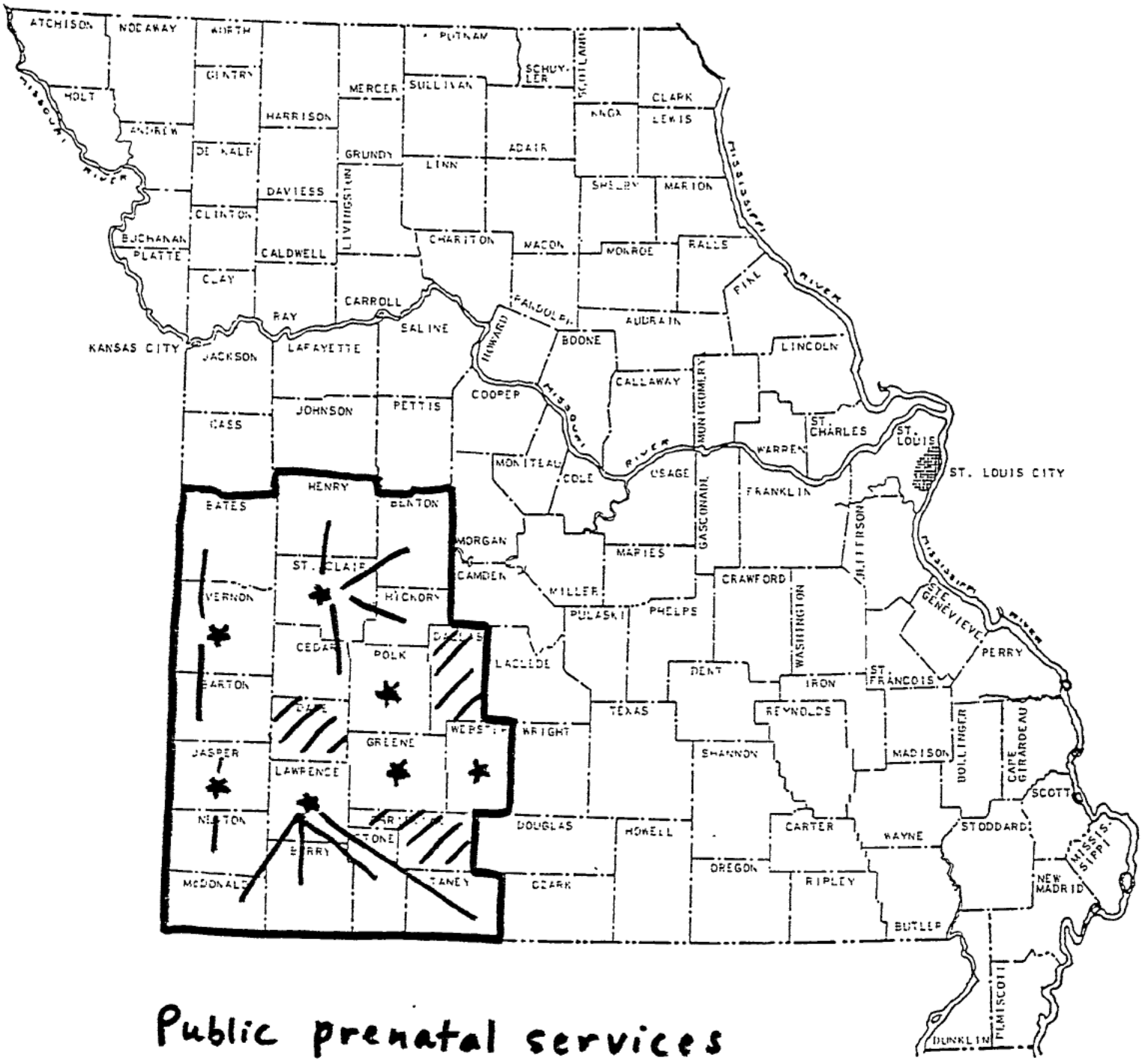
Even clinics with relatively few patients need a stable base income to provide the facilities and staff to offer a prenatal clinic.

Depending upon availability, patient load, and level of cooperation of the Medicaid physician serving an area, patients either remain in the public clinic throughout their pregnancy (if no Medicaid physician or that physician is too busy to assume care or feels the clinic setting offers superior care), or are referred out to a Medicaid physician once eligibility is determined (felt by many clinics to be in the patients' best interest, in order to provide an early link with the delivering physician. This decision by clinics/patients determines their ability to seek Medicaid global payment and thus significantly affects the clinic's ability to generate income. For example, clinics such as Springfield and Southwest Missouri Regional Prenatal Clinic who are now referring the majority (Medicaid eligible) of their patients to the delivering physician are having difficulty meeting operating costs.

MISSOURI DIVISION OF HEALTH

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

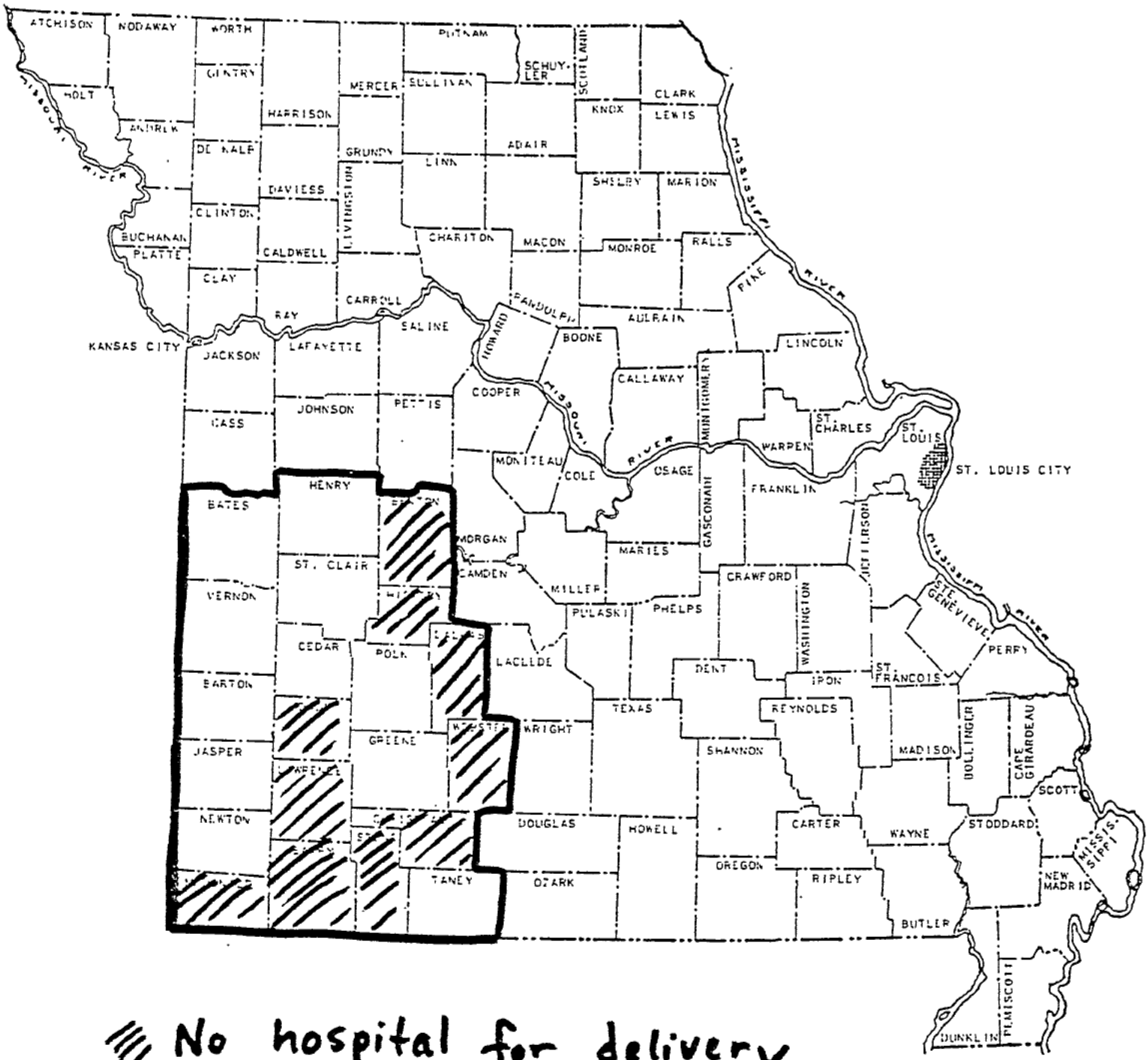
services provided on a nondiscriminatory basis



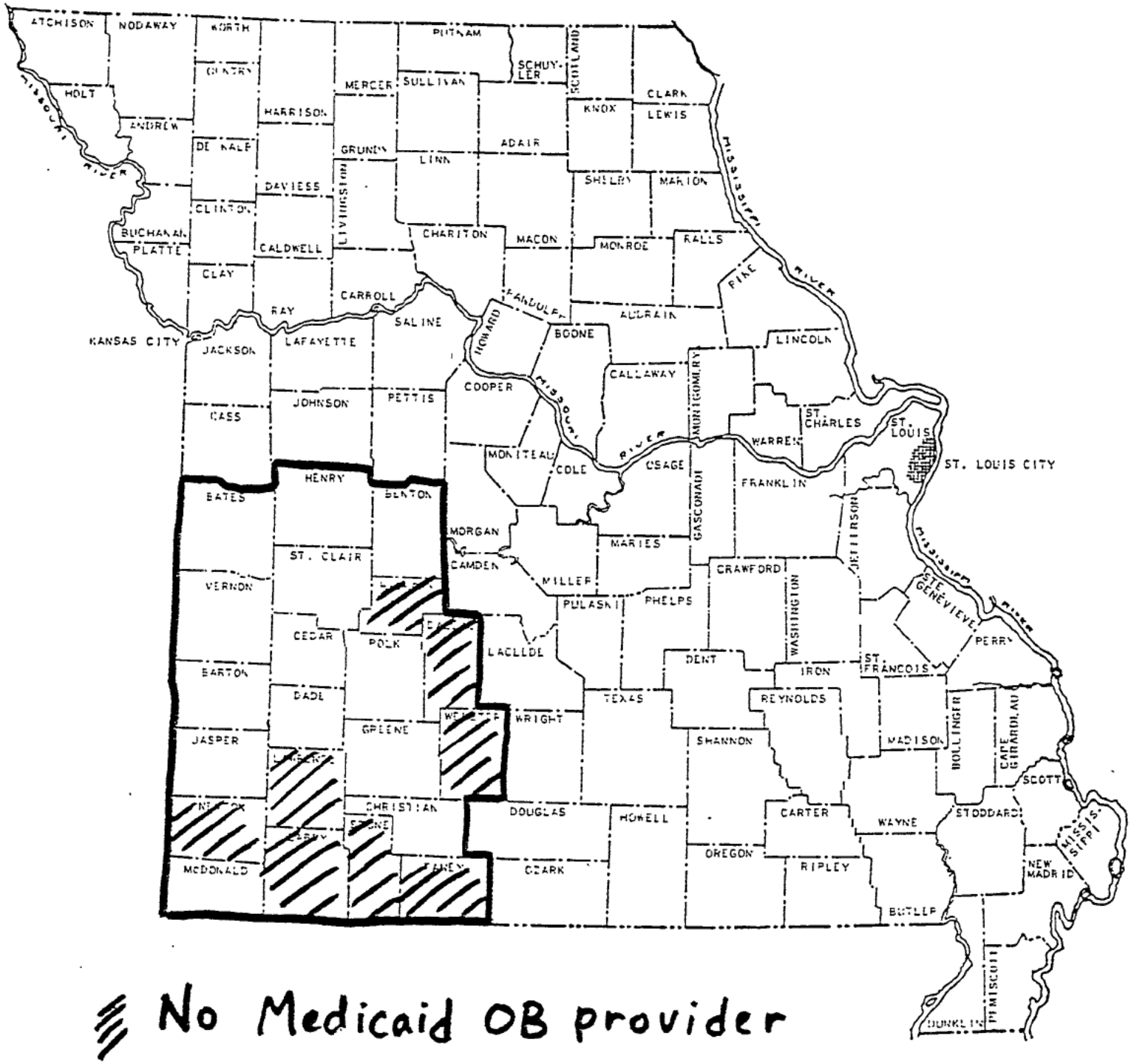
Public prenatal services

No public system available

DH - 12A



No hospital for delivery



No Medicaid OB provider

June 10, 1988

Otis Bowen, M.D.
Secretary, Department of Health and Human Services
Herbert H. Humphrey Building
200 Independence Avenue, S.W., Room 615F
Washington, D.C. 20201

Dear Dr. Bowen:

The Medicaid/Maternal and Children Health Technical Advisory Group (TAG), representing the State Medicaid Directors Association and the Association of Maternal and Child Health Programs has met for 15 months to address issues of maternity care for low income women and the most effective ways to reduce infant mortality and improve pregnancy outcomes in Medicaid populations. Based on these meetings and our review of infant mortality, the TAG has developed recommendations in the areas of eligibility, outreach, provider participation and content of care. These recommendations were presented to the National Commission to Prevent Infant Mortality on May 20, 1988. A copy of these recommendations is enclosed for your information and review.

These recommendations are the result of a cooperative process between Title V and Title XIX representatives at the national level. We feel that many can be implemented at the state and local level based on current statutory authority while others will require statutory and/or regulatory change. We request leadership and assistance from you and your staff in implementing these recommendations. The Association of Maternal and Child Health Programs and the State Medicaid Directors Association also request that the Department of Health and Human Services adopt the reduction of infant mortality as a high priority for the upcoming fiscal year.

We feel that a close working relationship between HCFA and HRSA at the federal level and between Medicaid and Maternal and Child Health agenices at the state and local level is key to the success of any infant mortality reduction initiative. We would like to commend you for your efforts to date in this area, and ask that these recommendations be given the highest priority as future policies to reduce the unacceptably high infant mortality rate for Medicaid recipients are developed.

Sincerely,

William H. Hollinshead, M.D., M.P.H.
President, Association of Maternal
and Child Health Programs

Aaron Johnson, Chair
State Medicaid Directors
Association

cc: William Roper, M.D.
David Sundwall, M.D.

Enclosure.

RECOMMENDATIONS
OF THE
MEDICAID/MCH TECHNICAL ADVISORY GROUP
TO THE
NATIONAL COMMISSION TO PREVENT INFANT MORTALITY
MAY 20, 1988

The Medicaid/Maternal and Child Health Technical Advisory Group (TAG) is composed of representatives of the State Medicaid Directors' Association and the Association of Maternal and Child Health Programs. The TAG has met for 15 months to address issues of maternity care for low income women and the most effective ways to reduce infant mortality and improve pregnancy outcomes in Medicaid populations. This document is the result of a cooperative process between Title V and Title XIX representatives at the national level, and the TAG strongly encourages similar cooperative efforts between state and local representatives of these agencies.

The TAG has reviewed data that demonstrates that the infant mortality rate for Medicaid eligibles is unacceptably and excessively high: the infant mortality rate for Medicaid recipients is 2 to 3 times greater than the rate for infants not on Medicaid.

It is clear that one of the most effective ways to reduce the likelihood of infant death is the provision of early and continuous comprehensive prenatal care. Despite recent legislative changes that have increased Medicaid eligibility levels, early entry into prenatal care is often prevented by eligibility barriers that serve to deny women the financial access to these essential services. The current Medicaid eligibility process is lengthy, cumbersome and complex. Many potentially eligible pregnant women do not know about the availability of prenatal services. Title V agencies have historically provided services

to some of these newly eligible Medicaid recipients, and have developed effective models of service delivery including case management, enhanted maternity services, outreach and community education. A few state Medicaid programs have adopted these services as Medicaid coverages. A close working relationship between Title V and Title XIX is essential to improve the accessibility and availability of high quality health care for low-income mothers and infants.

The TAG offers the following as its recommendations. The recommendations are in the areas of eligibility, outreach, provider participation and content of care.

ELIGIBILITY

1. The "de-linking" of eligibility for the Medicaid health benefit from eligibility for AFDC or other cash grant programs has occurred in OBRA '86 and OBRA '87. However, the eligibility requirements for pregnant women have not been operationally de-linked from income maintenance programs. Therefore, we recommend:

   - the asset test for pregnancy-related eligibility should be eliminated, not be an option. (This is the most cumbersome and time consuming element of the eligibility determination process requiring verification of bank accounts, automobiles, life insurance policies, property records, etc.)

   - eligibility should be continuous throughout pregnancy and 2 months post-partum for women and for the first year of life for infants. There should be no need for eligibility redeterminations during these periods of eligibility.

- the 4-D requirements (absent parent identification) should be waived until after the birth of the child.

- third party liability requirements (to determine the availability of other health insurance coverage) should be adressed to minimize the potential to be a significant barrier to timely eligibility and access to early prenatal care.

- application forms for pregnancy-related eligibility should be short and simple.

2. Applications for pregnancy-related Medicaid eligibility should be processed in a minimum timeframe. An expedited process and issuance of Medicaid cards should be required and monitored. Eligibility for pregnant women should be exempt from Federal Medicaid Eligibility Quality Control for at least 12 months.

3. The income standard of 185% of poverty should be a uniform national standard for pregnancy/infant-related Medicaid eligibility. The Medicaid matching rate for services provided to women and infants eligible under this standard should be increased to 90%.

4. Eligibility for minor pregnant adolescents should be based on their own income, and parental financial responsibility should be waived. (The data show that adolescents have the poorest pregnancy outcomes and the lowest likelihood of early prenatal care.)

5. The eligibility application process should be more easily accessible to pregnant women. Several options are possible, such as:

   - eligibility workers should be out-stationed at key service delivery sites.

   - application forms should be readily and generally available at multiple sites, including service delivery locations and social service agencies.

   - eligibility should be determined from application forms completed at service delivery sites, social service agencies, or as mailed directly by the applicant.

6. A study should be carried out to determine whether self-declaration of income would be more effective and appropriate for eligibility determination than the current method of verification and documentation.

7. Presumptive eligibility should be simplified, eliminating separate 5, 14 and 45-day limits. The restriction on referred outpatient services should be eliminated.

OUTREACH

The maternity population with incomes up to 185% of poverty is often not accustomed to Medicaid eligibility, and may not be aware of the availability of Medicaid-financed maternity care which they are newly eligible for.

1. A national media campaign should be undertaken to inform and educate the public on the urgent need to prevent infant deaths

and the importance of early prenatal care.

2. Outreach campaigns should be targeted to potentially eligible populations on the national, state and local levels.

PROVIDER PARTICIPATION

Avenues should be explored to improve provider participation in Medicaid for the provision of prenatal care and delivery services, with a focus on such factors as levels of Medicaid reimbursement, program requirements, and liability insurance.

CONTENT OF CARE

Not only should maternity care be accessible and available, but it should also be of high quality and appropriate to the needs of this population. The TAG has agreed that maternity care clinical standards should be utilized in Medicaid programs. The Maternal and Infant Health Guidelines developed by the Association of Maternal and Child Health Programs in conjunction with the State Medicaid Directors' Association should serve as the basis for those standards. The TAG feels that enhanced maternity services, including nutrition and psychosocial assessments and counseling, prenatal education and case management are effective ways of improving both the compliance with and the content of maternity care, and should be available to Medicaid recipients.

CONCLUSION

The Medicaid/MCH TAG believes that it is necessary to adopt a coordinated strategy that involves improvements in the eligibility process, outreach efforts, provider participation and content of care, and that these strategies will have a significant impact on infant mortality.

2513J

WHERE SHOULD MISSOURI GO FROM HERE?

In Webster v. Reproductive Health Services, Inc., the United States Supreme Court created legislative choices for Missouri. Essentially, Missouri may go three ways legislatively on the issue of abortion: (1) Do nothing; (2) Regulate abortion without directly challenging Roe v. Wade; or (3) Pass a bill which protects the lives of unborn children (without ignoring the mother) and which directly confronts Roe. The essential question is whether Missouri supports the right to life or the right to privacy during pregnancy as the superior right. If the choice is privacy, Missouri should do nothing. If the choice is life, Missouri must act. In deciding which direction Missouri should take, one must begin with the history of abortion regulation in Missouri and the commitment Missouri's Legislature has made to its citizens on this issue.

In 1986, as a part of the same bill which the United States Supreme Court upheld in Webster v. Reproductive Health Service, Inc., Missouri's Legislature made the following commitment to Missouri's citizens:

> It is the intention of the general assembly of the state of Missouri to grant the right to life to all humans, born and unborn, and to regulate abortion to the full extent permitted by the Constitution of the United States, decisions of the United States Supreme Court, and federal statutes.

Mo. Rev. Stat. §188.010 (1986).

This commitment was no accident. Missouri has traditionally and consistently prohibited abortion to the full extent permitted by law. Statutes prohibiting abortion on demand in Missouri go back almost to the very time Missouri became a state. For example, in 1825, Missouri's Legislature passed the following law:

> Be it further enacted, That every person who shall wilfully and maliciously administer or cause to be administered to or taken by any person, any poison, or other noxious, poisonous or destructive substance or liquid, with an intention him or her thereby to murder, or thereby to cause or procure the miscarriage of any woman then being with child, and shall thereof be duly convicted, shall suffer imprisonment not exceeding seven years, and be fined not exceeding three thousand dollars.

Mo. Rev. Stat., "Crimes and Misdemeanors", ch. I, §12 (1825).

In 1835, the Legislature extended protection to all unborn children, prohibiting all abortion procedures throughout pregnancy as follows:

> Every person who shall administer to any woman pregnant with a quick child, any medicine, drug, or substance whatsoever, or shall use or employ any instrument or other means, with intent thereby to destroy such child, unless the same shall have been necessary to preserve the life of such mother, or shall have been advised by a physician to be necessary for that purpose, shall be deemed guilty of manslaughter in the second degree.

Mo. Rev. Stat., "Crimes and Punishments", art. II, §10 (1835).

> Every physician, or other person, who shall wilfully administer to any pregnant woman, any medicine, drug, substance or thing whatsoever, or shall use, or employ any instrument or means whatsoever, with intent thereby to procure abortion, or the miscarriage of any such woman, unless the same shall have been necessary to preserve the life of such woman, or shall have

> been advised by a physician to be necessary for that purpose, shall, upon conviction, be adjudged guilty of a misdemeanor, and be punished by imprisonment in a county jail not exceeding one year, or by fine not exceeding five hundred dollars, or by both such fine and imprisonment.

Mo. Rev. Stat., "Crimes and Punishments", art. II, §36 (1835).

The Legislature amended these laws in 1907 and 1919 as follows:

> Any person who, with intent to produce or promote a miscarriage or abortion, advises, gives, sells or administers to a woman (whether actually pregnant or not), or who, with such intent, procures or causes her to take, any drug, medicine, or article or uses upon her, or advises to or for her the use of, any instrument or other method or device to produce a miscarriage or abortion (unless the same is necessary to preserve her life or that of an unborn child, or if such person is not a duly licensed physician, unless the said act has been advised by a duly licensed physician to be necessary for such a purpose), shall, in event of the death of said woman, or any quick child, whereof she may be pregnant, being thereby occasioned, upon conviction be adjudged guilty of manslaughter in the second degree, and punished accordingly; and in case no such death ensue, such person shall be guilty of the felony of abortion, and upon conviction be punished by imprisonment in the penitentiary not less than three or more than five years, or by imprisonment in jail not exceeding one year, or by fine not exceeding $1,000.00, or by both such fine and imprisonment; and any practitioner of medicine or surgery, upon conviction of any such offense, as is above defined, shall be subject to have his license or authority to practice his profession as physician or surgeon in the state of Missouri revoked by the state board of health in its discretion.

1907 Mo. Laws, pp. 230-231.

> Any person who, with intent to produce or promote a miscarriage or abortion, advises, gives, sells, or administers to a woman (whether actually pregnant or not), or who, with such intent, procures or causes her to take, any drug, medicine, or article, or uses upon her, or

> advises to or for her the use of, any instrument or other method or device to produce a miscarriage or abortion (unless the same is necessary to preserve her life or that of an unborn child, or if such person is not a duly licensed physician, unless the said act has been advised by a duly licensed physician to be necessary for such a purpose), shall, in event of the death of said woman, or any quick child, whereof she may be pregnant, being thereby occasioned, upon conviction be adjudged guilty of manslaughter, and punished accordingly; and in case no such death ensue, such person shall be guilty of the felony of abortion, and upon conviction be punished by imprisonment in the penitentiary not less than three years nor more than five years, or by imprisonment in jail not exceeding one year, or by fine not exceeding one thousand dollars, or by both such fine and imprisonment; and any practitioner of medicine or surgery, upon conviction of any such offense, as is above defined, shall be subject to have his license or authority to practice his profession as physician or surgeon in the state of Missouri revoked by the state board of health in its discretion.

Mo. Rev. Stat., §7336 (1919).

Finally, in 1969, Missouri made the final pre-Roe v. Wade Amendments to its abortion statutes:

> Any person who, with intent to produce or promote a miscarriage or abortion, advises, gives, sells or administers to a woman (whether actually pregnant or not), or who, with such intent, procures or causes her to take any drug, medicine or article, or uses upon her, or advises to or for her the use of, any instrument or other method or device to produce a miscarriage or abortion (unless the same is necessary to preserve her life or that of an unborn child, or if such person is not a duly licensed physician, unless the said act has been advised by a duly licensed physician to be necessary for such a purpose), shall, in event of the death of said woman, or any quick child, whereof she may be pregnant, being thereby occasioned, upon conviction be adjudged guilty of manslaughter, and punished accordingly; and in case no such death ensue, such person shall be guilty of the felony of abortion, and upon conviction be

> punished by imprisonment in the penitentiary not less than three years nor more than five years, or by imprisonment in jail not exceeding one year, or by fine not exceeding one thousand dollars, or by both such fine and imprisonment; and any practitioner of medicine or surgery, upon conviction of any such offense, as is above defined, shall be subject to have his license or authority to practice his profession as physician or surgeon in the state of Missouri revoked by the state board of medical examiners in its discretion.

Mo. Rev. Stat., §559.100 (1969).

Following Roe v. Wade in 1973, Missouri Legislature valiantly continued its commitment to unborn children by passing laws designed to challenge and limit Roe and its progeny. A number of these laws reached the United States Supreme Court and resulted in landmark decisions such as Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976); Planned Parenthood Assoc. of Kansas City, Mo. v. Ashcroft, 462 U.S. 476 (1983); and, most recently, Webster v. Reproductive Health Services, Inc.

Perhaps the most telling example of Missouri's commitment to unborn children is set forth in the simple but elegant language enacted as law in 1986 and upheld by the Court in Webster that "[t]he life of each human being begins at conception" and that "[u]nborn children have protectable interests in life, health, and well being." Mo. Rev. Stat. §1.205.1(1) and (2).

Yet, this was not the only expression of Missouri's position on protection of unborn children. In 1975, Missouri's

Senate approved the following Resolution 24 to 8 and Missouri's House of Representatives approved the same Resolution 112 to 36:

SENATE CONCURRENT RESOLUTION NO. 7

BE IT RESOLVED by the Senate, the House of Representatives concurring, that this legislature, pursuant to the authority granted by Article V of the Constitution of the United States, respectfully applies to the Congress of the United States to call a convention for the purpose of proposing the following article as an amendment to the Constitution of the United States:

ARTICLE--

Section 1. With respect to the right to life, the word person as used in this article and in the Fifth and Fourteenth Articles of Amendment to the Constitution of the United States applies to all human beings irrespective of age, health, function or condition of dependency, including their unborn offspring at every stage of their biological development

Section 2. No unborn person shall be deprived of life by any person; provided, however, that nothing in this article shall prohibit a law permitting only those medical procedures required to prevent the death of the mother.

Section 3. The congress and the several states have power to enforce this article by appropriate legislation.

BE IT FURTHER RESOLVED that a duly attested copy of this resolution be immediately transmitted to the Secretary of the Senate of the United States, the Clerk of the House of Representatives of the United States, and to each member of the Congress from this state.

Missouri's Governors have also consistently expressed a decidedly pro-life position. For example, in January of 1977, 1978, 1979 and 1980, Governor Teasdale issued the following Proclamation:

Office of the Governor
State of Missouri

PROCLAMATION:

WHEREAS, January 22, 1980, is the sixth anniversary of the United States Supreme Court decision which legalized abortion on demand; and

WHEREAS, the protection of the Constitution of the United States ought to apply to all human beings, irrespective of age, health, function or condition of dependency, including their unborn offspring at every stage of their biological development; and

WHEREAS, over seven and one-half million unborn children have been denied their "right to life, liberty and the pursuit of happiness"; and

WHEREAS, the people of Missouri and their elected officials respect God's gift of life:

NOW, THEREFORE, I, JOSEPH P. TEASDALE, GOVERNOR OF THE STATE OF MISSOURI, do hereby proclaim January 22, 1980, as a day in memoriam for these unborn children and urge all Missourians to recognize this day and fully participate in its observance.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, this 18th day of January, 1980.

/s/ Joseph P. Teasdale
Governor

Attest:

/s/ James C. Kirkpatrick
Secretary of State

In January of 1985 and each year since, Governor Ashcroft has issued the following Proclamation:

Office of the Governor
State of Missouri

PROCLAMATION

WHEREAS, January 22, 1989, is the 16th anniversary of the United States Supreme Court decision that legalized abortion on demand; and

WHEREAS, the protection of the Constitution of the United States ought to apply to all human beings, irrespective of age, health, function, or condition of dependency, including unborn children at every state of their biological development; and

WHEREAS, since 1973, over 23 million unborn children have been denied their "right to life, liberty and the pursuit of happiness"; and

WHEREAS, the people of Missouri and their elected and appointed officials treasure God's gift of life and have promoted life's protection through numerous programs, legislation, executive decrees, and judicial orders:

NOW, THEREFORE, I, JOHN ASHCROFT, GOVERNOR OF THE STATE OF MISSOURI, do hereby proclaim January 22, 1989, as a day in memoriam for these unborn children and urge all Missourians to recognize this day and fully participate in its observance.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, this 17th day of January, 1989.

/s/ John Ashcroft
Governor

Attest:

/s/ Roy D. Blunt
Secretary of State

As noted, Missouri's legislators and governors have consistently used the terms "child" or "unborn child" to refer to fetuses and embryos from the time of conception onward. From 1835 to 1907, abortions prior to quickening were essentially misdemeanors. From 1907 to 1973, even early abortions led to "felony abortion" convictions. Abortions of

unborn "quick" children led to more serious felony convictions for manslaughter.

Missouri's Legislature has also pursued its policy of protecting unborn children by creating and supporting alternatives to abortion. For example, the Legislature has provided special medical assistance to women who are pregnant (Mo. Rev. Stat. §208.151); special subsidies to facilitate certain adoptions (Mo. Rev. Stat. §453.070); and, tax credits of up to $5,000.00 for expenses related to the adoption of a "special needs child" (Mo. Rev. Stat. §135.327).

Other legislation designed to protect unborn children and oppose the philosophy and validity of Roe v. Wade include the abolishment of suits for wrongful life (brought by the child) and for wrongful birth (brought by the parents) (Mo. Rev. Stat. §188.130); the prohibition of Medicaid funding for abortion, except where the life of the mother is endangered (Mo. Rev. Stat. §208.152); persons and institutions refusing to participate in abortions cannot be discriminated against (Mo. Rev. Stat. §197.032); state-sponsored genetic diagnostic and counseling centers cannot refer for abortion unless the mother's life is endangered (Mo. Rev. Stat. §191.320); medical insurance coverage for elective abortions must be by optional rider requiring an additional premium (Mo. Rev. Stat. §376.805); and, abortions done with the intent to use fetal organs or tissues for transplants, and trafficking in fetal organs and tissues, are prohibited (Mo. Rev. Stat. §188.036).

Given the foregoing, it is inconceivable that anyone could reasonably argue that Missouri has anything other than the utmost commitment to the protection of unborn human life. This commitment is historical, philosophical and unerring. As stated by Missouri's Legislature as recently as 1986, "[i]t is the intention of the general assembly of the state of Missouri . . . to regulate abortion to the full extent permitted by the Constitution of the United States, decisions of the United States Supreme Court, and federal statutes." Mo. Rev. Stat. §188.010 (1986). It is now time for Missouri's legislature to live up to this commitment.

The question is then, what does the Webster case allow Missouri to do? It does not appear from the decision in Webster that the Supreme Court is, as yet, willing to uphold a state law which simply states that abortion is illegal

However, the Court does appear ready to recognize the State's ability to protect unborn children and extend rights to unborn children. A just law must also recognize the mother's rights with respect to pregnancy, while acknowledging that, under Missouri law, there is no right superior to the right to life. Thus, this Task Force recommends that Missouri pass a bill which protects the lives of unborn children (without ignoring the mother) and which directly contradicts Roe. To pass anything less would be to renege on a commitment to the protection of unborn human life, which is as old as the State of Missouri itself.

Lastly, Missouri must not ignore the fact that whatever law is passed will have consequences. Regulating or prohibiting abortion limits or stops the taking of unborn human life and thereby increases the number of pregnant women and the number of children. It is essential that Missouri recognize this fact and provides essencial services for these individuals.

The difficulties of pregnant women may be multiple and complex, and are best approached through a variety of services.

Such services, including an array of educational, health care, nutritional, and support services, are often not available to pregnant women who need them, or they are available but not known to them and thus of limited effectiveness in assisting them to carry their children to term, and providing proper care for children after birth, and in avoiding future dependency.

State policy should, therefore, encourage development of appropriate health, educational and social services where they are now lacking or inadequate, coordination of existing services where they are available, and development and utilization of private volunteer assistance in order to assist women to carry their children to term rather than abort them, and to help these women and their children to maximize their social and economic potentials. These women who give birth and their children need protection both before and after birth.

CONSEQUENCES OF ELECTIVE ABORTION

Most abortions in the United States are now performed out of the hospital in clinics or doctors' offices. For the most part, these offices follow high medical standards and provide a service at a cost far below other kinds of surgical care. These clinics also provide pregnancy tests and counseling to facilitate an early decision either to continue the pregnancy or to abort. The procedure is usually done under local anesthesia with a counselor in attendance to offer support and reduce anxiety. Most clinics also provide immediate contraceptive counseling and supplies and include one follow-up visit as part of their basic fee. Throughout the United States, the risk of illness or death from legal abortion has been markedly low. Overall, the risk of death from a first trimester abortion is about 1 per 100,000 abortions, making this alternative far safer than continuing the pregnancy. As shown in the table provided[1], the risk of death increases with gestational age and after 16 menstrual weeks, abortion, in general, is no longer safer than continuing the pregnancy. (Please see table Page 5) With the advent of the suction curettage, which can be used up to the 12th week of pregnancy, and in some cases beyond, dilatation and surgical evacuation of the uterus appears to be safer than postponing the abortion until 16 weeks, at which time intra-amniotic infusion methods may be used. Usually, after 14 weeks gestation, large dilators or an intracervical laminaria tent and special forceps are required for safe evacuation. Because of the availability of low cost out-of-hospital first trimester abortions, 92% of legal abortions are now performed in the first trimester when abortion is the safest.

Anesthetic technique also influences the maternal morbidity and mortality. The use of a general anesthetic greatly increases the risk of perforation of the uterus, visceral injury to the bowel, hemorrhage, hysterectomy, and death. The preferred alternative is probably paracervical block with a local anesthetic and low dose sedation--analgesia as needed. The effects of an elective abortion on subsequent pregnancies continues to be disputed. For example, a World Health Organization Task Force on Sequelae to Abortion[2] reported a significantly higher risk of an adverse pregnancy outcome among women whose only previous pregnancy had been aborted than among women who were either primigravida or whose only previous pregnancy had ended in a live birth. However, Cates[3] analyzed and tabulated 19 reports concerned with the apparent impact of previous abortion

on subsequent pregnancies, concluded that the data did not support firm conclusions about induced abortion sequelae. More recently, Chung and co-workers[4] and Linn and Associates[5] have reported that in their extensive studies that previous induced abortions did not seem to significantly increase the risk of an adverse late pregnancy outcome in a subsequent pregnancy.

Let us briefly review the reported first trimester abortion complications. As stated above, while general anesthesia adds to the hazards of vacuum and sharp curettage, a local paracervical block also has its risks. An intravascular injection or an overdose of Xylocaine can produce a severe systemic response to include convulsions, cardiorespiratory risks, and death. In addition, a so-called clinical shock syndrome can be set up when vasovagal syncope produced by the stimulation of the cervical canal occurs. Brief tono-clonic activity can be observed, but is distinguished from a true seizure by the presence of a very slow pulse, the patient's rapid recovery, and the absence of any post ictal state.

Clinical experience in previous years with an "incompetent cervix" supports the concept that this uncommon defect can follow induced abortions. It seems possible that the forceful dilatation of the cervix by surgical or medical techniques sufficient to allow evacuation or expulsion of an advanced pregnancy can predispose to cervical incompetency and cervical lacerations. Slater and Associates[6] who have provided supporting data in this regard, urge that all women who undergo induced abortion should have the abortion as early as possible to minimize cervical damage and its later consequences.

Uterine perforation is probably the most feared complication of vacuum curettage because injury to major blood vessels, bowel, or bladder may result and the life of the patient may be jeopardized. Uterine perforation sustained at abortion were usually perforations of the cervix, either at the junction of the cervix or in the lower uterine segment in the lower portion of the cervical canal. Perforations of the junction of the cervix and low uterine segment can lacerate the ascending branch of the uterine artery giving rise to severe pain, broad ligament hematoma and intra-abdominal bleeding. Such perforations are usually recognized soon after they occur. They can be managed by laparoscopy to confirm the injury and then by laparotomy to ligate the severed vessels and repair the uterus. Hysterectomy should not be necessary to manage such an injury. However, low

cervical perforations alternatively may injure the descending branch of the uterine artery with the dense collagenous substance of the cardinal ligaments. In these cases, there is no intra-abdominal bleeding, but rather external bleeding through the cervical canal. Deaths have occurred when a low cervical perforation is not appreciated and bleeding recurred several hours or even days after the original trauma. This injury usually requires hysterectomy for successful management.

Grimes and others[7] studied the epidemiology of uterine perforation using information from 67,175 abortions. The rate of perforation was .9 per 1,000. The risk of perforation is greater for patients of more advanced gestational age as it is for women of higher parity. The use of a laminaria tent seemed to reduce this risk as did greater operator skill. Other complications of induced medical abortion included hemorrhage, excessive bleeding during the vacuum curettage, and a postabortal syndrome called hematometra. Additionally, a failed abortion (failure to interrupt the pregnancy) and incomplete or septic abortions can result from an improperly performed procedure. All of these complications are reduced when the health care provider is experienced and competent.

Synechiae (uterine scarring) that compromise the uterine cavity as a consequence of abortion or vigorous curettage have resulted in infertility. Treatment for this syndrome (Asherman Syndrome) is usually successful using hysteroscopic techniques. However, there are incidences of placenta accreta and cervical pregnancy following this uterine scarring event.

In summary, it must be remembered that the elective induced abortion has a finite complication rate and the number of complications increase in direct proportion to the number of weeks of pregnancy to be considered. In the studies reviewed, it seems that in competent clinical hands, first trimester elective induced abortions continue to be relatively safe procedures with very few postabortal complications. Induced abortion has been a recognized method for family and population control throughout the world. Japan and Hungary are two countries that have successfully used this technique for population control. The success of these programs probably rests on the availability of broad spectrum antibiotics and the suction curette. However, it is not a completely innocuous procedure and the clinical skill of the health care provider is of utmost im-

portance as this procedure is performed. The wastefulness of time and expense in terms of physician and hospital utilization, as well as moral and ethical aspects, allows abortion to be regarded only as a backup procedure for method failures, not as a contraceptive method.

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November 14, 1989

DEATH TO CASE RATE FOR LEGAL
ABORTIONS BY WEEKS OF GESTATION
IN THE UNITED STATES, 1972 - 1980

Weeks of Gestation	Deaths[a]	Abortions[b]	Rate[c]	Relative Risk[d]
< - 8	19	4,073,472	0.5	1.0
9 - 10	31	2,382,516	1.3	2.6
11 - 12	25	1,197,915	2.1	4.2
13 - 15	20	419,767	4.8	9.6
16 - 20	55	430,907	12.8	25.6
> 21	14	91,343	15.3	30.6
TOTAL	164	8,595,920	1.9	

a Excludes deaths from ectopic pregnancy

b Based on distribution of 6,108,658 abortions (71.1%)

c Deaths per 100,000 abortions

d Based on index rate of < 8 menstrual weeks gestation of 0.5 deaths per 100,000 abortions

REFERENCES

[1]Center for Disease Control: Abortion Surveillance 1979-80, January 1983.

[2]World Health Organization Task Force on Sequelae to Abortion: Gestation, birthweight and spontaneous abortion in pregnancy after induced abortion. Lancet 1:142, 1979.

[3]Cates, W., Jr.: Late effects of induced abortion. Hypothesis or Knowledge? Journal of Reproductive Medicine 22:207, 1979.

[4]Chung, C. S., Smith, R. G., Steinhoff, P. G., M-P: Induced abortion and spontaneous fetal loss in subsequent pregnancies. American Journal Public Health 72:548, 1982.

[5]Linn, S. Schoenbaum, S.C., Monson, R. R., Rosner, B., Stubblefield, P. G., Ryan, K. J.: The relationship between induced abortion and outcome of subsequent pregnancies. American Journal Obstetrics and Gynecology 146:136, 1983.

[6]Slater, P. E., Davis, A. M., Harlap, S.: The effect of abortion method on the outcome of subsequent pregnancy. Journal of Reproductive Medicine 26:123, 1981.

[7]Grimes, D.A., Schulz, K. F., Cates, W. J., Jr.: Prevention of uterine perforation during curettage abortion. JAMA 251:2108, 1984.